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# Essential Music Therapist Attributes for Relationship-Building with Children: Does our Profession Train Personal Abilities?

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Essential Music Therapist Attributes for Relationship-Building with Children:  
Does our Profession Train Personal Abilities?

A DISSERTATION  
(Submitted by)

Jean M. Nemeth

In partial fulfillment of the requirements  
for the degree of  
Doctor of Philosophy

LESLEY UNIVERSITY  
May 2014



Lesley University  
Graduate School of Arts & Social Sciences  
Ph.D. in Expressive Therapies Program

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## ABSTRACT

The purpose of this sequential mixed method investigation was to discern the personal attributes that a music therapist employs to engender therapeutic relationships with children and to begin ascertaining the music therapy profession's attempts to foster these qualities in music therapy students. The overarching goals of this dissertation were to identify aspects of relationship-building that go beyond skills, techniques, and theoretic orientation and to open a discussion about how to best address training of the person of the music therapist. The Phase One phenomenological inquiry consisted of thematic cross-comparison of in-depth interviews with five highly experienced children's music therapists. Results revealed strong participant agreement about essential personal attributes and relationship-building aptitude which centered on personal qualities, relational abilities, cognitive abilities, and the music. These findings then served as the basis for the Phase Two quantitative survey of 119 music therapy educators and clinical trainers which sought to corroborate the Phase One results and investigate whether and how these abilities were currently being addressed within music therapy education and training. Results indicated >90% overall agreement with the delineated attributes and relational abilities among survey participants. Strong consensus was also evidenced in relation to the importance of possessing these abilities and belief that personal attributes and relationship building skills were currently being addressed within student training. Modeling, discussion, and role playing were overwhelmingly cited as the preferred teaching strategies and music therapy methods courses and clinical practica were indicated as predominant instructional milieu for addressing personal attributes. Survey responses also demonstrated near unanimous agreement that, though difficult, these

abilities can be trained. However, discrepancy between educator perceptions of efficacy and reported student response, a lack of emphasis on personal qualities within mandated educational competencies, disagreement between educators and clinical trainers about where in the training curriculum these qualities should be addressed, and potentially inadequate teaching strategies make questionable the participant perception that personal attributes are being adequately addressed. Discussion of the overall results, limiting factors, and implications for further research were presented.

## CHAPTER 1

### Introduction

#### An Illustrative Tale

*An oft-repeated scenario: The phone rings...a voice on the other end, often female—mother...grandmother...aunt—occasionally a dad. “Hello, I am looking for a music therapist... and you come highly recommended,” is usually how it all begins. The voice starts in timidly most times, searching for just the right amount of emotional nuance or convincingly persuasive words. “I have a son (daughter/grandchild/ nephew/young friend...) who I think could benefit from music therapy.” Then it starts to roll, gaining momentum and nervous energy. Soon a life story unfolds...be it autism, developmental disabilities, mental illness, physical impairment...a story of infinitely subtle variations...yet uncannily the same. “My child needs more!” is the sentiment and “I’m searching for best chance I can give him...and I think music therapy may be it!” I listen silently, intermittently signaling my support and agreement. Then it comes: “Would you be willing to work with my child?” “Unfortunately,” I must respond, “My caseload is full...But I can recommend another music therapist...” The cut-off retort is always rapid-fire:*

*“NO! We don’t want **A** music therapist! We Want **YOU!**”*

So what is this “you” factor? What is it that makes one music therapist more effective and potentially more sought after than another? This notion of ‘you-ness’ has repeatedly surfaced throughout my long career as a children’s music therapist. Across recurring scenarios similar to the above depiction as well as within ongoing discussions amongst colleagues and recipients alike, the realization that efficacious therapeutic liaison relies on more than technique or methodology alone has remained salient.

Indeed, at times it seems as though uniquely personal qualities factor into an earned reputation at least as prominently as technical competency. This insight was never more starkly illustrated than during my involvement with an aborted research effort focusing on the effectiveness of a music therapy intervention in allaying children’s fear during out-patient surgery. Despite obtaining some level of positive outcome, the researchers deemed the results to be simply a case of *therapist effect*—attributable only to

one clinician's personality and relational abilities, without regard for the potential efficacy of the music therapy intervention itself (Kain, et al., 2002).

Instances such as these have caused me to repeatedly ponder the multifaceted nature of creating a therapeutic relationship. What a music therapist brings to this interactive process and the attributes of self that invariably lie at the core of productive liaison have frequently given rise to deep musing. Ultimately, it has been the intriguing nature of these contemplations coupled with ongoing collegial discussions about how to best train future music therapists that have brought me to the present inquiry.

### **Music Therapist Effectiveness in Context**

It has long been held within the psychology and counseling communities that productive liaison between counselor and client underlies effective therapy (e.g., Farber & Lane, 2001; Gordon & Toukmanian, 2002; Weisz, Weiss, Alicke, & Klotz, 1987). It could easily be argued from a common sense standpoint that successful music therapy intervention is inherently dependent upon such interaction between therapist and client as well. However, to date, only limited research—generally qualitative in nature—has actually been focused on this area within music therapy discourse (e.g., Comeau, 2004; Muller, 2008).

Nonetheless, the music therapy profession relies heavily upon the ability to train clinicians to be effective service delivery agents, both in the techniques they employ and in their ability to develop nurturing relationships with those they serve. Historically, emphasis has primarily been placed on development of effective intervention methods (American Music Therapy Association, 2000). Numerous research efforts have focused on particular client populations, specific methodology, and theoretical models (2000). In



addition, the field has adopted a competency-based education model to ensure equality of skills among entry-level music therapists (American Music Therapy Association, 2013).

Yet, why does it appear that individual disparities between practitioners continue to exist? It seems reasonable that acquisition of set competencies would result in equality of skills and techniques across music therapy clinicians. Then, what is it that potentially renders one music therapist more effective than another equivalently trained peer? How does the 'you factor' enter into clinician development and subsequent practice?

Discerning music therapist competence requires looking beyond technical knowledge. Regardless of theoretical orientation, a music therapist's ability to foster a productive working alliance may very well rely upon less quantifiable attributes of personality, intuition, disposition, and insight brought to the setting. Yet, due to the predominance of positivist research with a strong behavioral stance, the vast majority of music therapy inquiries have remained largely focused on specific treatment techniques or effecting positive response within particular client populations (American Music Therapy Association, 2000).

Far less emphasis has been placed on those personal qualities that align with therapist effectiveness. To date, the music therapy research literature has remained chiefly tacit on the subject of how a clinician's personal attributes, demeanor, or personality relate to effective delivery of quality therapeutic intervention. Yet, it can be argued that aspects such as attunement abilities, personality characteristics, and intuitive sense may be central to establishing the therapeutic relationship necessary for promoting desired outcomes (e.g., Blow, Sprenkle, & Davis, 2007). What are these qualities and how do they affect the therapist-client relationship? Specifically, how do these qualities

align with the developmental needs of children? Foremost, what is it that fosters the perception of one music therapist as being more effective than another similarly trained clinician? Lastly, as a profession, how do we address personal qualities of the therapist within the training process?

### **Problem Statement**

It can be argued that the ability of a music therapist to engender an effective therapeutic relationship with a client lies at the core of successful intervention. This process inherently involves utilizing one's personal attributes and relational abilities to establish and maintain productive interpersonal connection with those we serve. Nevertheless, it seems that the music therapy profession has remained primarily focused on technique, methodology, and theoretical orientation both within clinical discourse and in the training of music therapy students as well.

Despite informal agreement amongst practicing clinicians that relational qualities are central to success as a music therapist, the personal attributes that a music therapist relies on in fostering positive outcomes with children remain largely unspecified in the discourse. Not only has there been a paucity of literature focused on this fundamental component of music therapy intervention, only general references to the significance of therapist attributes and therapeutic relationship are made within the American Music Therapy Association (AMTA) Professional Competencies (2013) which serve as the blueprint for music therapy training:

#### **9. The Therapeutic Relationship**

9.1 Recognize the impact of one's own feelings, attitudes, and actions on the client and the therapy process.

9.2 Establish and maintain interpersonal relationships with clients and team members that are appropriate and conducive to therapy

9.3 Use oneself effectively in the therapist role in both individual and group therapy, e.g., appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired therapeutic outcome (AMTA, 2013)

Thus, it remains necessary to more fully discern the parameters of therapeutic relationship within music therapy clinical work. A music therapist's essential personal attributes and their role in establishing productive working alliance with children are important to establish. In addition, ascertaining how development of these core qualities is presently addressed during the general training of future music therapy practitioners has yet to be fully described.

### **Statement of Purpose and Goals**

The purpose of this study was to illuminate those personal attributes of a music therapist that are essential for engendering effective therapeutic relationship with children and to assess the music therapy profession's attempts to foster these vital qualities in all music therapy students. The overarching goal of this dissertation was to begin identifying the aspects of therapeutic relationship formation that go beyond skills, techniques, and theoretical orientation for the purpose of opening a discussion about how these essential components are, can, and should be incorporated into the education and clinical training process of future music therapists. A desired outcome was increased professional focus on the importance of training the whole person of the music therapist in order to facilitate development of the best possible methods of fostering high quality, relationally-oriented clinicians. By addressing both methodology and personal attributes, future music therapy

practitioners could potentially be better equipped with the necessary capabilities to best promote our profession and, above all, serve our clientele.

### **Method of Inquiry and Research Questions**

This investigation took the form of sequential mixed method investigation which was comprised of two phases: a phenomenological, interview-based inquiry followed by a quantitative survey process. Phase One analysis of in-depth interviews with five highly experienced children's music therapists attempted to demarcate those personal qualities and attributes beyond skills, technique, or theoretical grounding that a music therapist employs to establish therapeutic relationship with children. Drawing on this information, Phase Two applied a quantitative survey process to ascertain level of agreement amongst music therapy educators and clinical trainers about the importance of these delineated qualities. The survey then sought information about how the development of these attributes is currently addressed within the general training of music therapy students and interns. Educators' and clinical trainers' beliefs as to whether personal attributes are amenable to training was also explored.

It is important to note that while Phase One specifically addressed clinical work with children, the present "professional level of practice" or "bachelor's degree" training in music therapy as defined by the AMTA Professional Competencies (2013) is not specialized according to client population. This fact necessitated that Phase Two remain focused on the general training of all music therapy students.

Specifically, this two-part study addressed the following research questions:

1. What are the personal attributes that experienced music therapists see as essential to their ability to engender effective therapeutic liaison with children?

2. What are the important components of relationship building as delineated by experienced music therapists?
3. To what level do music therapy educators and clinical trainers agree with the importance of these delineated personal attributes?
4. How is development of these essential personal attributes currently incorporated into the training of music therapy students and interns?
5. Do music therapy educators and clinical trainers think personal attributes are amenable to training? If so, how; if not, why not?

### **Assumptions, Guiding Statements, and Limitations**

In undertaking the present study, the researcher must acknowledge a number of assumptions that guided all phases of this investigation. Foremost was a firm belief that engendering a productive therapeutic relationship is central to effective music therapy intervention. Moreover, the personal attributes and deportment of a music therapy clinician were deemed to be as important to successful intervention as well developed technique and theoretic orientation. In addition, it was held that disparities among individual music therapists' abilities to engender effective relationship with children do exist. The supposition was also made that the music therapy profession has yet to adequately address the 'person' of the therapist in the training of music therapy students.

The following guiding statements were developed based on these assumptions:

1. Effective music therapy clinicians possess personal attributes and relational abilities that align with developing a productive therapeutic relationship with child clients.

2. Educators and clinical trainers will agree that the personal attributes delineated by experienced children's music therapists are important for all music therapists to possess.

3. Currently, development of these essential personal attributes is not adequately addressed within the education and training of music therapy students.

Lastly, a potential limiting factor must be acknowledged. Assuming that the findings about essential attributes of children's music therapists applies more widely across all clinical practitioners in the field may prove less than accurate. It is possible that other personal qualities figure more prominently in working with alternate client populations, an issue that would require investigation that exceeds the boundaries of the present inquiry.

### **Rationale and Significance**

Given recent increases in media exposure (e.g., YouTube, 2014) and generally higher public awareness (AMTA, 2014), it is incumbent on the music therapy profession to ensure that highly qualified practitioners are available to provide services to a potentially growing consumer base. While it is imperative that clinical intervention be based on firm theoretical understanding and effective evidence-based technique, it is also important to acknowledge that music therapy is provided by the person of the music therapist. As noted, to date, the bulk of research within the music therapy literature addresses technique, theoretical orientation, or population specific effects of particular treatment paradigms (AMTA, 2000). Only limited, qualitative discourse has explicitly addressed the person of the music therapist in relation to how personal attributes affect a

clinician's ability to establish effective therapeutic relationships (e.g., Milgram-Luterman, 1999; Wolfe, O'Connell, & Epps, 1998).

Nonetheless, my personal experience has repeatedly accentuated the perception that the personal attributes and relational abilities that a therapist possesses are often of equal or greater importance than technique, skills, or theoretical foundations. Beginning to discern precisely what these characteristics are as well as whether and how these essential personal attributes can be developed in future music therapy clinicians is important to the advancement of the music therapy profession. It is hoped that research into essential personal attributes of effective music therapy clinicians will not only deepen our profession's knowledge base but more importantly expand discussion about the importance of training the whole therapist.

## CHAPTER 2

### Review of the Literature

#### Overview

Music therapy is defined as “the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who had completed an approved music therapy program” (AMTA, 2010a, p. vi). As denoted, the music therapy process involves music-based interactions which are situated within a therapeutic relationship between music therapist and client. While this definition emphasizes the use of music to facilitate productive client outcomes, it cannot be overlooked that the conveyance medium for this process is the interpersonal relationship.

Thus, in seeking to expose the essential attributes of an effective music therapist, it is necessary to begin by focusing on relationship. Any discourse pertaining to music therapist competence must look beyond technical knowledge. Long recognized within the therapeutic community, the underpinnings of successful intervention lie within the relationship established between therapist and client (e.g., Miller & Stiver, 1997, p. 120). Cultural anthropologist Mary Catherine Bateson (1994) described human interaction as “a habit of patterned relationship... sufficiently pervasive to provide most human beings...with an experience of how separate organisms can interact in harmony” (p. 221). Therapy has often been described as a highly relational, interactive process (e.g., Blow, Sprenkle, & Davis, 2007, p. 310). As such, it is critical to discern those personal traits necessary to engender an efficacious therapeutic environment and establish the attuned interaction necessary to expedite successful clinical outcomes.



By definition, to attune is to “adjust (a person or thing) to a situation” (Pearsall & Trumble, 1995, p. 88). Attunement has been described as “how well one senses, interprets and reacts promptly and appropriately to another’s signals, allowing the other person in the interaction to feel *understood*” (Robertson, Dow, & Hainzinger, 2006, p. 152). Philosopher Martin Buber (1970) set the tone for any discussion of therapeutically attuned relationship:

The basic word I-You can be spoken only with one’s whole being...I require a you to become; becoming I, I say you. All actual life is encounter (p. 62)...

In the beginning is the relation...What counts is not these products of analysis and reflection but the genuine original unity, the lived relationship. (pp. 69-70)

This sentiment was further explicated by noted psychologist, Maslow:

I-thou knowledge, knowledge by experiencing, knowledge from within, love knowledge, being-cognition, fusion knowledge, identification knowledge...are...more predictive of reliable and valid knowledge *if* we are trying to acquire knowledge of a particular person...If we wish to learn more about persons, then this is the way we’d better go about it (1998, p. 83).

A wide variety of terminology has been posited to describe the concept of attuned interpersonal relationship. Terms such as collaboration, communion, connection, empathy, rapport, coordinated attention, joint engagement, joint attention, affect-laden or intention-filled social interaction, primordial sharing, and positive regard have all been offered as illuminating descriptors of this phenomenon (e.g., Adamson, Bakeman, Deckner, & Ronski, 2009; Farber, & Lane, 2001; Fink-Jensen, 2007; Oetzel & Scherer, 2003; Tickle-Degnen & Rosenthal, 1990). In addition, specific types of attunement (e.g.,

affect attunement, cue attunement, musical attunement) have elicited discourse as well. Poulsen and Fouts (2001) described affect attunement as “a special kind of inter-subjective relatedness in which there is a match of internal states and a sense of emotional connectedness between two individuals” (p. 185). Kossak (2006) denoted affect attunement as:

A felt embodied experience that can be individualistic as well as communal, that includes a psychological, emotional, and somatic state of consciousness.

Attunement can also be thought of as *bringing into harmony* or a feeling of *being at one with another being*. (p. 14)

Cue attunement, as defined by Boone and Cunningham (1998), involves decoding “emotional meaning from structural cues embedded within an expressive display” (p. 1007). A nonverbal form of intuitive communication, attunement is often described in lay terms as “tuning in,” feeling that natural, unspoken, intuitive connection with another person (Kossak, 2006, p. 13). Ultimately, attuned relationship inevitably relies on the interactive capacities and relational capacities that therapeutic partners possess.

It is thus necessary to ascribe importance to the personal qualities that a music therapist brings to the therapeutic relationship. Delineating these features inevitably encompasses demographic characteristics such as age, gender, race, theoretic orientation, and experience. In addition, the role of less quantifiable features such as personality, disposition, personal attributes, feelings, beliefs, and authenticity require clarification. As noted by prominent educator, Parker Palmer (1998), “We teach who we are. Teaching, like any truly human activity, emerges from one’s inwardness, for better or worse” (p. 2). Similarly, it can be argued that effective therapy relies on this self-knowledge as well.

Palmer further commented, “Technique is what you use until the therapist arrives” (1998, p. 5). This statement underscores the reality that a true therapeutic alliance invariably relies on more than technical competence; personal connection must serve as the foundation of effective therapy.

When considering a therapist’s essential personal qualities for working with children, focus must turn to the unique needs of young people. Engaging in child therapy undeniably entails working within the developmental process. Regardless of the presence of debilitating or disabling conditions, children continue to grow and develop. Learning to interact socially with others, an important aspect of relational development, is an ongoing process for all children (e.g., Feldman, 2009, pp. 344-350; Mussen, Conger, & Kagen, 1970, pp. 407-409).

Moreover, immersed in the ongoing developmental process (Feldman, 2009), children cannot be viewed simply as mini adults. As a result, research findings based solely on adult clientele must be viewed skeptically when the focus is child therapy. Issues pertaining to work with children necessitate consideration of education as well as child development literatures —both implicitly child-centered. The investigation must also take into account the natural milieu of child activity, as delineated in developmental and play therapy discourse. Play is the “process of development for a child” (Gil, 1991, p. 27), or put more simply, “play is the work of childhood” (Woolf, 2011, p. 179). Perhaps this in part explains why music therapy, which invariably involves *playing* music, has long been successful in effecting positive outcomes with child populations (Brown & Jellison, 2012; Humpal & Colwell, 2006).

Lastly, of equal importance to ascertaining those personal attributes and relational

capacities that enable music therapists to foster productive therapeutic alliances with children is examination of how those qualities are developed as part of the education and training process of future music therapy clinicians. Possessing knowledge of essential music therapist attributes remains superfluous unless these understandings can be applied in a practical fashion. Therefore, it will also be necessary to examine current education and training practices within the field of music therapy. First, however, a review of the current status of discourse pertaining to a music therapist's essential personal attributes and relational abilities is warranted.

*“When we are moved by music we may speak of musical attunement.*

*Musically attuned people interrelate with music and articulate*

*meaning in movements, facial expressions, or singing,*

*pictures, drama, and verbal expressions”*

(Fink-Jensen, 2009, p. 56).

### **Essential Attributes in the Music-Based Relationship**

Examination of therapist attributes, attuned relationship, and relationship with children have received only tangential focus within the music therapy literature. Historically, the majority of the professional discourse has instead accentuated technique or specific population response (American Music Therapy Association, 2000; Brown & Jellison, 2012). To date, effectiveness research has generally emphasized the measurement of treatment methods, not therapist impact (American Music Therapy Association, 2000). Moreover, the sparse number of studies that do accentuate attuned relationship or therapist qualities have focused either on adult populations, individual therapy paradigms, or parent-child dyads (e.g. Amir, 1996; Brescia, 2004; Trondalen &

Skarderud, 2007; Walworth, 2009). Nonetheless, a limited number of investigations have shed light on dimensions of the therapist's personal and relational qualities question.

### **Quantitative Investigation of Music Therapist Essential Attributes**

Not surprisingly, the topics of therapist personality, personal attributes, or attunement were found to be largely absent within music therapy literature that employed positivist methodology. However, several quantitative researchers have made forays into this area. Wolfe, O'Connell, and Epps (1998) highlighted the importance of "supportive" content in a music therapist's verbalizations. In attempting to identify how to effectively train clinicians as group leaders, instructor verbalizations were found to be highest in supportive content (56 %), of which 79% focused on eliciting student responses. While offering interesting perspective on how music therapists employ verbal techniques, this study focused on student training, not clinical work. Moreover, limitations imposed by the single-case design rendered the specificity of stipulated recommendations questionable.

Alternately, Jones and Cevalco (2007) compared nonverbal behavior of professional and student music therapist dyads ( $N = 3$ ) in a two-part pilot study of work with elders in dementia care. Findings indicated that experienced clinicians displayed a wider range of facial expressions (students generally smiled throughout), more purposeful movement patterns, and closer proximity to clients than their student counterparts. Investigators emphasized the need to provide specific feedback as students did not imitate the modeled behaviors of their professional partners and proved unaware of their less proficient responses. This limited scope research would have benefited from greater observer reliability on proximity measures (70 %) as well as replication across

settings, populations, and larger participant samples.

Cevasco (2010) further assessed the effects of a music therapist's nonverbal behavior on the participation and affective responses of patients with Alzheimer's or related dementias ( $N = 38$ ). While findings indicated that a clinician's nonverbal affect (facial expression; eye contact; mirroring; movements) and proximity both influenced patient response and engagement, combining affect with proximity resulted in a 79% increase in patient on-task, accurate response and a 62% upswing in patient affect as well. This combination proved more effective than affect alone (75% response and 53% affect) or proximity alone (71% and 30%). The researcher stressed that music therapists need to remain aware of their non-verbal presentation, but noted that further research was warranted to more broadly assay the effects of affective countenance on therapist-client rapport, therapeutic relationship, and treatment outcomes. Cevasco also noted, "Further research is merited to determine how and when music therapy students learn and acquire appropriate nonverbal skills when working with various populations" (2010, p. 297).

Milgram-Luterman (1999) proposed that skills and knowledge alone are insufficient for attaining therapeutic proficiency and accentuated the importance of life-long learning. In outlining a theory for achieving a "disposition of music therapy excellence" (p. 24), the author purported ongoing emphasis be placed on self-awareness gained through supervision or personal counseling, leading to an "attitude of expertise" (p. 31). However, even though this article presented a compelling theoretical model for music therapist development, it did not specifically address clinical therapeutic relationship.

Silverman (2011) compared a song-writing application with talk-based intervention to assess psychiatric patients' understanding of coping skills and working alliance. While results of this single session outcome study indicated no significant between group difference in measured knowledge, the experimental group ( $N = 45$ ) demonstrated better working alliance, higher perception of enjoyment, and greater attendance. The results of this very limited investigation appeared to indicate that group songwriting can be at least as effective as talk-based intervention for establishing working alliance. Despite emphasis on therapeutic relationship, however, this analysis focused on client outcomes, not therapist contribution.

An increasing number of studies have begun to look at the physiology underlying music's ability to act as a social bonding mechanism. For example, a recent inquiry by Novis-Livengood (2013) sought to illuminate the brain functions (perception, emotion and cognition) that align with adolescents' development of socially-acquired music preference. Studying the activation of a subject's cortical neurons which correlated with a peer's voiced opinion about music selections, findings indicated that adolescents, notably between the ages of 12-15, were highly sensitive to peer opinion juxtaposed on music listening and altered preferences accordingly. Further somatic investigation can be found in the work of Leslie (2013) who measured musical engagement. Though such physiological studies have examined aspects of musical experience and children's social relationships, as yet, they have not emphasized therapist contributions.

Other studies focused on parameters of a music therapy career. Analyzing a two-part survey of 272 randomly selected board certified music therapists (57.8% return rate), Choi (2008) established that a therapist's theoretical orientation (e.g., cognitive-

behavioral; analytic; psychodynamic) did not appear to be a factor in successful service delivery. Fowler (2006) noted that cognitive coping strategies and self-efficacy correlated strongly with career longevity, though she cautioned that comparative assessment of these qualities with those of practitioners who abandoned the field had proven difficult.

While assessing professional burnout in music therapy, Vega (2010) more specifically identified personality characteristics that aligned with prolonged careers as music therapists: emotional sensitivity, reasoning (problem solving skills), apprehension (sensitive worriers), warmth (comfortable with connection), openness to change (experimental; nontraditional thinkers), self-reliance, extraversion (people oriented), and anxiety (reactive), abstractness (deep thinkers), rule consciousness (high personal standards), and self-control. Again, despite focusing on music therapist characteristics, none of these studies directly assayed the music therapist-client relationship.

**Research with College Students.** A few researchers have begun to look at aspects of personality in collegiate music majors. Madsen and Goins (2002) investigated internal versus external locus of control of reinforcement among groups of college students participating in musical ensembles. Interestingly, music therapy majors demonstrated higher levels of external locus of control, perhaps indicating that students who selected a therapy profession may have greater tendency to look to others (relational focus) for validation.

In an investigation of college music majors' personality profiles (Steele & Young, 2008), both music education and music therapy students reported higher levels of public service. These groups also aligned with Extrovert-Intuition-Feeling-Perception (ENFP) personality types on administered Myers Briggs Type Indicator (MBTI) tests, indicating



warm, enthusiastic, imaginative and help-oriented personalities. Moreover, in a follow-up study of professionals, Steele and Young (2011) again found close similarity between music educators and music therapists. Professional music therapists' presented as INFJ (introvert-intuition-feeling-judgment) while educators aligned with ENFJ (extrovert-intuition-feeling-judgment) on MBTI profiles, indicating that music therapists displayed a more inward-looking, reflective perspective than music educators, while both groups retained the a helpful, other-orientation. In comparing these results to their earlier student inquiry, only small personality type changes appeared to occur over time for members of these professions. However, the authors stressed the preliminary nature of these findings and the need for further investigation.

Three research efforts investigated methods of assessing students' affect or predicting future clinical success. Madsen, Madsen, and Madsen (2009) reported on preliminary testing of a "concise emotional inventory" (p. 2) designed to provide a quick measure of present emotional state that could prove useful for therapists. The authors cautioned that while their results confirmed that the inventory could be expeditiously implemented; further norm testing and validation were warranted.

Gregory (2009) employed student ratings of brief clinical videos to assess recall of their personal comfort and skill self-attribution in relation to various clinical experiences. Results indicated that student recall was stronger for personal than clinical experiences and that direct clinical music therapy experiences had a strong positive impact on students' self-perception of their skills. Gregory proposed that the study's methodology for measuring students' self-attributions could potentially be useful in selection and retention of students appropriate for a music therapy career.

Recently, Kim (2011) reported the results of preliminary testing of the “Music Therapy Career Aptitude Test” or MTCAT (p. 395) designed to measure affective domains including a student’s personal awareness of the music therapy profession, interest in general therapy or human development, and personal aptitude for a music therapy career. Strong content validity was demonstrated by comparing responses of 113 music therapy students with 43 professionals, indicating potential for predicting music therapy career aptitude. Wider application and further norm testing remain necessary however.

While these collegiate-based research efforts may appear tangential, they do indicate that researchers are beginning to ascribe significance to the person of the music therapist, albeit generally restricted to student populations.

### **Qualitative Investigation of Musical Relationship**

Therapist attributes and relational abilities have been more closely examined within the qualitative music therapy discourse, notably in the areas of attunement, therapist effectiveness, and intuitive presence. Two studies focused specifically on affect attunement. Amir (1996) employed a grounded theory approach to plumb those seemingly time-altering “meaningful moments” (p. 119) of attuned therapist-client musical interaction. Thematically, she described these moments (e.g., moments of acceptance, freedom, beauty, wholeness, etc.) as “experienced on multiple levels,” “difficult to describe,” and “happening spontaneously” (pp. 119-120). In a phenomenological study of a client with eating disorders, Trondalen and Skarderud (2007) evoked affect attunement in describing musical-relating experiences as links between body and mind. These researchers identified the essential elements of these

experiences as attentiveness to timing, intensity, and form (p. 109).

Several case studies sought to expose relational dimensions. Shrager (2006) reported on a music-based intersubjective approach based on collaborative therapist-patient probing of meanings in preferred musical selections. The author noted that, “the vehicle for change and growth might not lay in the music alone, but in the relatedness between patient and therapist that occurred around the music” (p. 93). Ansdell, Davidson, Magee, Meehan, and Procter’s (2010) preliminary interdisciplinary findings of a phenomenological case study demonstrated music’s apparent efficacy in assisting a woman with psychosis to “modulate affect in a creative way within a surprisingly short time span” (p. 3). Lastly, in a phenomenological case study of a client subjected to cumulative trauma, Auf der Hyde (2012) probed the merits of musical improvisation for providing bi-directional co-regulation opportunities. She concluded that while rhythmic interaction did appear to facilitate both intra-psychic and interpersonal regulation, intervention seemed most productive at the mid-level range of coordination where an “optimal arousal state” (p. 72) or “flow” (p. 99) allowed a client to access the “social engagement system” (p. 15) to self-regulate.

Ahonen-Eerikäinen (1999) surveyed 54 Finnish music therapists and analyzed their written reports to ascertain how these clinicians utilized music and their particular working styles when treating children. Results indicated that music therapy work encompassed multiple paradigms—e.g., structured and unstructured; “wide-scoped” or “one-method” ideology (p. 159)—and that “a therapist’s personal music therapy profile often differed with regard to how committed he is to certain working paradigms, methods, and theories or philosophies and how flexible...or how narrow his ideas of

music therapy for children are” (p. 159). Additionally, Shoemark and Groeke (2010) utilized data from a large multi-disciplinary study of children in hospitals to discern the interplay between a music therapist and three high risk infants. The researchers discerned 20 sets of relational responses employed by clinicians—categorized under the headings of enticing (e.g., anticipate, invite, share a moment), responsive (e.g., affirm, reciprocate, emulate), and directive (e.g., pre-empt, contain, support)—and offered specific behavioral descriptions.

A phenomenological investigation by Jackson (2008) also sought to illuminate music therapist’s relational responses, this time practitioners’ experiencing of and response to client anger. A survey of 29 board-certified music therapists of varying clinical orientations provided the data for this multiple case study design. Findings indicated a “menu concept” (2008, p. 88) with therapists drawing from four general response categories: a redirection model (change/ extinguish client anger), a validation model (encourage/support client expression), a containing model (encourage safe, focused expression of anger), and a reflection model (reflect client anger-work through the emotion to find resolution). A therapist’s choice of model(s) in each case appeared situational. Not surprisingly, the participants expressed visceral reactions to being targets of client anger—e.g., fear, safety concerns, surprise (pp. 52-53)—and noted using music-based relationship as the container or vehicle for processing anger. Jackson commented, “Any study focusing on anger must be couched within the context of the therapeutic interaction of the therapist, the client, and the music” (p. 5). Of note, this research’s methodology proved similar to the present endeavor—each case was first analyzed individually according to its individual merits before an overall comparison was made.

Other qualitative inquiries more specifically addressed aspects of music therapist attributes. Brescia (2004) sought to discover how music therapists experienced and used intuition within client sessions. Applying purposive sampling in a phenomenological design, the author interviewed six experienced music therapists to explore their experiences of using intuition during improvisational music therapy sessions with a variety of client populations. These therapists collectively indicated that physical (body sensations), emotional (inner sense), auditory (the music; inner voice), and visual (imagery) messages as well as a spiritual dimension denoted their personal awareness of intuitive processes. In addition, the conditions that enabled them to access and use these cues included trust in the message, self-awareness, deep listening (to self; client; environment), and drawing upon previous experience. Above all, the participants stressed that their relationship with the client supported their ability to access and employ intuition as a means to move the therapy process forward.

In a phenomenological study of eight experienced music therapists, Muller (2008) assayed the relational quality of music therapists' experiences of being present for clients. The author offered axioms of being present as a balance between: immersion in the moment/music and reflection upon it, being intentional and being open, experiencing emotion and channeling it therapeutically, and adapting intentionally while experiencing the music as the client does. Similarly, Bae (2011) investigated the relationship between clinical music listening and a music therapist's decision-making. Seeking to understand how therapeutic interventions are selected, this multiple-case naturalistic inquiry examined how three theoretically divergent music therapists (creative, neurologic, cognitive-behavioral) approached clinical music listening. Bae found that while all three

participants listened analytically to understand a client's music and reflectively in relation to case specifics, specific listening approaches and intervention decisions varied according to clinical perspective. She stressed that these internal processes were critical factors both in determining a music therapist's immediate musical decision-making and ultimately in shaping musical relationship.

A naturalistic inquiry examined music therapists' experiences of participating in a group music therapy process. Arnason (1998) identified themes of embracing intuition, employing "guidance and sense of direction" (p. 56), maintaining an open, flexible "wait and see" approach (p. 64), and fostering a sense of "collectivity" in the group (p. 118) as "valuable companion[s] to conscious clinical interventions and decisions" (p. 17). Interviewees emphasized "use of self as a means for creating a musical and therapeutic relationship" (p. 16)

Similar in methodology to the present endeavor, Comeau (2004) investigated music therapists' personal experiences of effectiveness or ineffectiveness through a phenomenological interview process. Self-perceived efficacy or ineptness indicators included perceptions of self-as-therapist (e.g., state of mind, emotional reactions, specific techniques/ actions), perceptions of the client's experience (e.g., mood, response), and the usefulness of applied therapy methods. Interestingly, the participant responses tended to be described on a continuum (i.e. spontaneous vs. self-conscious; positive vs. negative mood, etc.) However, this effort focused solely on therapist self-report and did not specifically address effectiveness with children.

One additional study addressed therapist self-awareness. Camilleri (2001) employed self-analysis to explore the self as an essential tool in music therapy. She

concluded that increased self-awareness led to improvement in her music therapy competence and authenticity. However, these findings must be viewed as offering only limited value to the present discussion due to the heuristic nature of this effort.

Collectively, these qualitative efforts offered theoretical depth and potential scope to the topic of essential music therapist attributes by delineating aspects of attuned responding, specific therapist-client interactions, working style, personal characteristics, and therapist relational abilities. However, by design, the proffered results were not intended to afford generalization across individuals or settings.

### **Child-Focused Relationship and Music**

Only a few music therapy studies directly addressed therapeutic abilities or therapist role in work with children. Employing an observation-based, pre-post design, Gold, Wigram, and Voracek (2007) studied 15 music therapists' interventions with 75 children and adolescents referred for individual therapy. The authors reported that relationship-fostering music improvisation techniques were more effective in increasing positive outcomes of children and adolescents with emotional, behavioral, or developmental disorders than non-specific interventions such as free play. These findings held true across multiple settings and therapists.

Likewise, Kim, Wigram, and Gold (2008) successfully applied improvisational music therapy to increase joint attention and non-verbal communication abilities of autistic children. Videotape analysis (rater reliability: 89-97%) indicated that increases were greater under improvisational music conditions (presumably relational) than during play sessions, especially when music therapy was administered by an experienced professional. It is important to keep in mind, however, that these improvisational music

interventions were typically associated with individual therapy which may limit their applicability in group-oriented child settings.

Carpente (2009) assessed the effectiveness of combining Nordoff-Robbins Music Therapy (NRMT as described in Nordoff & Robbins, 1964) with a relationship-based DIR®-Floortime™ model (Greenspan & Weider, 2006) across four individual case studies with children diagnosed on the Autism spectrum. Mixed method analysis included quantitative examination of therapeutic outcomes and qualitative description of the process. Results indicated that each child made progress on identified music-based relational goals (e.g., self-regulation; engagement; two-way purposeful communication; problem solving; shared attention). In denoting NRMT's ability to enhance DIR effectiveness within these limited case applications, the researcher-therapist described being able to "initiate and form relationship within musical play" (2009, pp. 156-157).

Similarly, Kalas (2012) assessed joint attention of children on the Autism spectrum. Findings of this matched sample outcome study indicated that children with severe autism displayed higher levels of joint attention in response to simple music while those with mild to moderate autistic tendencies were more attuned to complex musical selections. The author noted that a therapist's "careful manipulation of specific musical elements can help provide the optimal conditions for facilitating joint attention with children with ASD" (p. 430).

Two studies from the music education literature addressed musical attunement or teacher responsiveness. Fink-Jensen (2007) employed phenomenological-hermeneutic analysis to highlight the importance of recognizing "bodily dialogue" (p. 61) when ascertaining students' musical attunement and the need for teachers to respond



appropriately to these non-verbal communications. Costa-Giomi, Flowers, and Sasaki's (2005) study of piano students determined that, irrespective of skill level, those students who terminated piano study within the first year sought teacher approval and verbal cues more frequently than their matched peers who continued in training for three or more years. This study, though not directly addressing teacher responsiveness, did point to the importance of remaining attuned to children's indirectly expressed needs.

Though the qualitative nature or case specific scope of the above studies restricts wider applicability, collectively they remain helpful in highlighting facets of nonverbal interaction and relational capacity.

**The parent-child dyad and music.** In recent years, the parent-child dyad has come under repeated scrutiny in the general discourse (e.g., Campbell & Johnston, 2009; Strand, 2000). Not surprisingly, the music therapy literature has paralleled this trend as well. Music therapy researchers have investigated the parent-child relationship, music interventions to assist child-caregiver alliance, specific child populations, and parenting skills, to name a few.

Oldfield, Adams, and Bunce (2003) compared the efficacy of different formats of short-term music therapy group intervention in fostering positive engagement of parents and very young children. Examination of three group conditions (play & music toddler sessions; a single session/follow-up discussion with mothers of children with psychiatric issues; a regular nursery school music therapy program) indicated that all investigated short term group formats were highly effective in engaging both children and adults and facilitated more positive parent-child relationships. However, higher levels of negative responses were witnessed in the mothers of clinically-referred children, which the

researchers postulated may represent carry over from problems reported at home. The authors also noted the positive aspects as well as the constraints associated with researching in actual clinical environments.

Loveszy (2005) reported on individual mother-infant dyad music therapy treatment for women in substance abuse rehabilitation programs. Results of this qualitative inquiry indicated that this model was successful in fostering more positive mother-child relationships, appropriate child development, and personal growth-ego strength improvement for the mothers. The author denoted essential music therapist abilities as: being spontaneous and child-centered, working within a collaborative therapy team, and relying on improvisational music's immediacy and non-verbal effectiveness. Moreover, the author commented:

The therapeutic relationship with mothers and infants is a special one...this relationship invites growth from the deepest core of both mother and infant. It also invites growth from the therapist. It is the responsibility of those who are therapists to learn from their work in order to enhance the therapeutic process (Loveszy, 2005, pp 192-193).

Recommendations included wider model dissemination across settings and populations and longer-term intervention regimens to combat post-therapy recidivism found both in this study and across this clinical population.

Developmental music therapy intervention with parent-infant dyads was investigated by Walworth (2009). Fifty-six matched parent-infant (premature or full term) pairs were divided between music therapy and control groups. Significant increase in social toy play ( $p < .05$ ) was witnessed in the music therapy group while graphic

analysis indicated that parent responsiveness increased as well. Both premature and term infants benefitted from increases in positive parent play behavior and relational responsiveness.

Pasaili (2012) employed music-based rehearsal strategies to enhance productive ways of connecting and develop a “mutually responsive orientation” (p. 303) in in a qualitative study of mother-young child dyads. Participants included four low income families whose mothers presented with histories of depression. Therapist actions included encouraging and modeling music-based interactions to enhance relational parent-child bidirectional activity, harmonious communication, mutual cooperation, and emotional ambiance (pp. 314-315).

Several recent efforts specifically highlighted dyadic interventions for children with special needs. Williams, Berthelsen, Nicholson, Walker, and Abad (2012) described a large scale outcome study ( $N = 201$ ) that focused on the effectiveness of short-term relationship-based music therapy groups for dyads of parents and children with disabilities. Improvements were seen in parent mental health, parenting sensitivity, parental acceptance of and engagement with their child along with children’s increased communication, responsiveness, social skills, interest, and participation.

Gilboa and Roginsky (2010) found that the combination of music therapy and dyadic treatment was effective in increasing communication and more coordinated relationship between a mother and child with cerebral palsy. In a qualitative study by Choi (2013), two parent-young child with special needs pairs (Autism; Downs Syndrome) benefitted from home or clinic based music experiences which fostered relational responsiveness and provided opportunities to learn musical parenting strategies.

Lastly, Jacobsen and Wigram (2007) presented a tool for assessing parenting competency for families with children potentially in need of services. Of note, this experiential music-based assessment affords therapists the ability to examine the parent-child relationship and interactions that serve as relational foundations. The authors noted that “the therapist has a unique role both as a participant in a parent-child interaction, and as an observer” (p. 129)

Overall, the cited music-related literature, though somewhat exiguous, does speak to dimensions of therapist effectiveness, essential qualities, and attunement. Nonetheless, most of the quantitative work did not directly assay therapist attributes that facilitate therapeutic alliance. Conversely, though not designed to provide generalizable results, a number of the designated qualitative studies did more closely address therapeutic attributes or attunement. Yet, their usefulness remains restricted to identifying potential parameters of the topic.

Of equal importance, the music therapy discourse currently displays far less focus on addressing therapeutic relationship with children. The majority of the included works either focused on adults, individual therapy, or parent-young child dyads—and were noticeably insufficient in encompassing the diversity of child therapy milieus. As a result, it is necessary to move beyond the music therapy discourse for further clarification of the topic of essential therapist attributes and relational effectiveness.

### **Therapist Attributes and Effectiveness**

In contrast to the limited scope of pertinent music therapy research, the psychology literature has offered multiple perspectives on therapist attributes and relational effectiveness. For example, Trudeau and Reich (1995) noted that psychology

students tended to display higher levels of psychological mindedness—defined as “awareness of one’s and others’ thoughts, feelings, and motives” (p. 699)—and greater self-awareness than their peers in the humanities or social sciences. Highlighting more detailed aspects of relational methodology, Jeffrey (2008) commented that “supervisors need to understand the dynamics (e.g., a supportive, encouraging relationship of trust) under which [the essential attribute of] intuition can be fostered” (p. i).

Understandably, the child psychology literature has emphasized treatment practices in child therapy, frequently including dimensions of therapist effectiveness (e.g., Weisz, Weiss, Alicke, & Klotz, 1987; Shirk & Karver, 2003). Additionally, the general psychology discourse has quite specifically delineated aspects of therapist characteristics, skills, and effectiveness, as well as examining the relational dimensions of attunement, rapport, and joint attention.

### **Children and Psychology**

In comparison with adults, the advent of literature pertaining to child psychology represents a fairly recent phenomenon. In 1909, Sigmund Freud presented the first documented account of psychotherapy work with children (Gil, 1991, p. 26). However, even as recently as the early 1960s, researchers were cautioned against inclusion of women, children, or minorities in participant samples, due to fear that their “unpredictability” would confound otherwise “clean” data (Robb, 2002, p. 23).

Since that time, however, ever-expanding work in child psychology has produced a wide array of research findings. To gain perspective on this burgeoning field, Weisz, et al. (1987) conducted a meta-analysis of 108 well-designed studies to evaluate the variety of treatment methodologies employed in child therapy. Results indicated that treated

children displayed better adjustment than 79% of their non-treated peers. Therapy containing a behavioral component proved most effective, regardless of age, therapist experience, or presenting problem. Of pertinence to the present topic, successful outcomes were attained equally by experienced, inexperienced, or student therapists, lending credence to the notion that therapist effectiveness is dependent upon more than technical expertise alone.

Shirk and Karver (2003) further delineated relationship-outcome associations in a smaller meta-analysis ( $N = 23$ ) of investigations drawn from the child and adolescent therapy literature. Results indicated that therapeutic relationship was most strongly associated with global functioning changes while, surprisingly, only moderately aligned with outcomes. Divergence of treatment methodology, children's varying developmental levels and presenting conditions as well as the relatively small sample size were all cited as probable factors affecting the results. Nonetheless, modest but consistent association between therapeutic relationship and outcomes was evinced for all age levels surveyed. This correlation between therapeutic alliance and improved global functioning may also lend credibility to the centrality of therapist-child liaison.

### **Therapist Characteristics, Skills, and Effectiveness with Children**

Vital to success in child therapy is the ability of the therapist to engage children, either verbally or non-verbally, in processes that will "alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior" (Weisz, et al., 1987). A wide array of research efforts assayed the therapist's role in facilitating progress. Several representative studies were chosen for examination here.

A study of children's group therapy ( $N = 100$ ; ages 9-12) conducted by

Leichtentritt and Schechtman (1998) examined the role of the therapist in promoting child self-disclosure and group therapy goals. Analyses of verbal responses indicated that the major role of the therapist was to structure activities, model self-disclosure, and engage children through questioning. Therapist actions included supporting group members, assisting constructive group feedback, encouraging here-and-now interaction, setting positive norms, and enhancing therapeutic factors necessary for change (p. 43). All of these techniques denote supportiveness and responsiveness as important therapist attributes.

The impact of therapist behavior on client noncompliance was the focus of a study by Patterson and Forgatch (1985). These researchers conducted two reversal design studies utilizing therapist-mother dyads in an effort to train effective child management skills. Results indicated highest compliance when therapist behavior facilitated or supported mothers' efforts; non-compliance rose sharply when mothers were confronted or given direct instruction. Results remained consistent across all six dyads and followed expected patterns of increase and decrease across all testing conditions. Here again, salient characteristics of effective therapist behavior were support and facilitation.

Schechtman (2004) studied the relationship between client behavior and therapist helping skills in group and individual treatment of highly aggressive boys ( $N = 51$ ). The therapist technique most strongly associated with positive client verbal response was asking questions (supporting), while presenting challenges (confrontation) resulted in the most pronounced negative reactions. Highest levels of verbal response occurred within individual therapy; however, short, simple verbalizations predominated across both settings. Despite the relative success of supportive, helping techniques, participants'

affect exploration, insight gains, and behavioral change remained low. The researchers noted that outcome limitations may have resulted from the intransigent nature of this presenting condition as well as the inability to control for age within the groups.

Positive regard, alliance building capacities, and bonding abilities were repeatedly noted as effective therapist attributes in the adult literature. Farber and Lane's (2001) literature review indicated a strong association between therapists' positive regard and successful therapeutic outcomes. The investigators summarized prior reviews as well as 16 new studies conducted after 1990. While describing effect size as generally modest across these research efforts, the authors noted that positive regard's usefulness may lie in its ability to facilitate long term relationships.

Similar results were obtained in a study of supervision style by Schacht, Howe, and Berman (1989). Supervisee effectiveness gains were strongly correlated with supervisors who employed supportive empathy and positive regard in their interactions with their employees. In an earlier study, Hayden (1975) also ascertained that the best therapists infuse the therapeutic relationship with empathy, positive regard, and genuineness.

In relation to children, positive regard and collaborative efforts proved effective in promoting therapist-child alliances and therapeutic bonding. Kazdin, Marciano, and Whitley (2005) studied 185 children presenting with oppositional, aggressive, or antisocial behavior. Supportive cognitive-behavioral intervention—which sought to engender feelings of therapist-child alliance—combined with parent management training that encouraged parent-child alliance increased children's acceptance of treatment and resulted in greater therapeutic gains. However, this study's simultaneous application of



parent and child treatment regimens diminished the ability to extrapolate individual treatment effects and hindered generalizability of the outcomes.

Three other studies also established a positive correlation between therapeutic alliance, bonding, or attachment and successful treatment outcomes for children. Creed and Kendall (2005) found that collaboration positively predicted early child ratings of alliance and was far more effective than “finding common ground” or “pushing the child to talk” strategies (pp. 503-504) in promoting positive outcomes with anxiety disordered children. The authors noted, however, that while relational alliance is important within successful treatment, it should not be considered an effective treatment regimen in and of itself.

Schechtman and Katz (2007) successfully utilized therapeutic bonding as a means of increasing social competence of children with learning disabilities and attention deficit disorders. Experimental group participants ( $N = 42$ ) benefited from attending small group therapy sessions where counselors employed an expressive-supportive modality (p. 124) to encourage self-expression and group support. Therapist-child alliance led to increased social competence of participants over control group levels but did not engender friendship formation within the confines of this short-term intervention.

Schuengel, Sterkenburg, Jeczynske, Janssen, and Jongbloed (2009) implemented a six case, alternating treatment design to study affect regulation in children with pervasive multiple disabilities. A technique of supportive mirroring produced significantly higher therapeutic attachment as compared to the control condition of positive personal attention only. Resulting attachment was then successful in decreasing psycho-physiological arousal (e.g., respiratory arrhythmia) under stressful behavior

modification conditions. Of interest in this study was supportive techniques' effectiveness in engendering therapeutic attachment even with children who possessed profoundly disabling conditions.

Lastly, a meta-analysis of 49 youth studies conducted by Karver, Handelsman, Fields, and Bickman (2006) identified 29 constructs of therapeutic relationship. The investigators determined that the therapist attributes most predictive of positive outcomes with youth clients were interpersonal skills (e.g., empathy, positive regard, self-disclosure, openness, warmth, trust) and direct influence behaviors (e.g., clearly presented information with rationales).

In summation, psychology discourse pertaining to therapist attributes designated the attributes of positive regard, empathy, mirroring, genuineness, supportiveness, responsiveness, and the ability to create therapeutic alliance, bonding, or attachment as strongly correlated with therapist effectiveness. All these qualities appeared to assist in fostering the positive therapeutic relationships necessary to engender positive outcomes with clients.

### **Attunement, Rapport, and Joint Attention**

As noted earlier, the concept of attunement is multi-dimensional. Kossak (2006) and Fink-Jensen (2007) viewed affect attunement as a natural part of an arts making process. Kossak went on to describe attunement's importance in expressive arts therapy work:

Therapeutic attunement can be viewed as being based on an embodied awareness of rhythmic flow, and on mutual connections that occur when there is an intense process of deep listening, kinesthetic awareness, and deep attention to what is

occurring in the moment (Kossak, 2006 p. 15).

Tickle-Degnen and Rosenthal (1990) proposed a conceptualization model of rapport whose three interrelated components—mutual attentiveness, positivity, and coordination (p. 286)—shift in relative importance as a relationship progresses. In addition to the psychological aspects that “create powerful interpersonal influence and responsiveness” (p. 285) between individuals, they also described behavioral attributes in the form of body movement, facial expression, eye gaze, and posture (p. 290). More recently, Oetzel and Scherer (2003) discerned that therapists needed to express empathy, be genuine, employ developmentally appropriate strategies, incorporate choice making, and address the stigma of therapy to engender effective therapeutic engagement with adolescents.

Psychology research has more directly attempted to delineate the parameters of attunement and effectiveness than investigations in the music therapy literature. Davis and Hadiks (1994) designated nonverbal aspects of therapist body position (e.g., leaning in), movement (e.g., limbs, torso, head), and gesticulation intensity (e.g., hands) as valid measures of emotional involvement and rapport. These authors, however, did not measure whether these aspects correlated with positive treatment outcomes.

Attunement was found to be the most significant factor in creating empathy (Gordon & Toukmanian, 2002) and correlated with greater complexity of client processing (Macaulay, Toukmanian, & Gordon, 2007). Results indicated that the level of support and connection displayed by the therapist affects how deeply clients process experiences. Both investigations emphasized that the manner in which interventions are conveyed was of central importance.

Attunement in the form of joint attention and engagement was examined in a study that compared language emergence in young children with Autism or Down's syndrome with typically developing toddlers. Adamson et al. (2009) employed systematic longitudinal observation to assess development of joint attention and whether differences in symbol-infused joint engagement affected expressive and receptive language outcomes. Joint attention to objects enables caregivers to match the language symbol to the attended object, allowing the child to gain access to the symbolic representation necessary for language development. While not the central focus of this study, adult ability to foster joint attending was crucial to child success in acquiring vocabulary and symbol representation, especially for children with special needs.

Cumulatively, these research efforts illuminated dimensions of attuned relationship in the forms of joint engagement, rapport, emotional involvement, and verbal or nonverbal attention. These discussions lent weight to the importance of engagement and attunement abilities as attributes of the effective music therapist. Of equal importance, many of the cited studies directly addressed the therapist's relational role when working with children.

### **Essential Attributes in Counseling**

Analogous to music therapy, the counseling profession's impetus lies in ameliorating disability and dysfunction within the therapy paradigm. Such correlated emphasis deems discourse in this area important for consideration. Here again, the literature addressed therapist social support, interpersonal relationship, and working alliance.

An early study by Hayden (1975) established a relationship between a therapist's

verbal behavior and effectiveness. Efficacy was seen as dependent upon experienced therapists' (n = 20) display of empathy, positive regard, and genuineness as well as a tendency to rely on an inward, presumably reflective, focus. Jennings and Skovholt (1999) delineated essential characteristics of master therapists as being avid learners, drawing on experience, attending to personal well-being, possessing strong relational skills, trusting therapeutic alliance, and having the ability to apply exceptional relationship-building skills. Additionally, Wheeler and D'Andrea (2004) denoted the importance of acquiring the "skill of immediacy" (p. 117) as an important aspect of counselor training. Paralleling the psychology literature, Daw and Joseph (2010) recently addressed the importance of psychological mindedness, noting that therapists and counselors needed to remain cognizant of clients' motives, distortions, or inner experiences.

In a comprehensive review of research findings, Blow et al. (2007) discussed the role of the therapist in couple and family therapy. They pointed to the therapist's ability to identify and maximize change opportunities as the strongest determinants of the therapist's as well as the intervention's effectiveness. While acknowledging the complexity involved, knowing "what to do" (p. 318) and being adept at responding to clients in ways that move the process forward were seen as key elements of effective therapy. Specifically, the results pointed to alliance building, engagement, hope-expectancy generation, relational conceptualization of problems, adapting to changing meanings, and matching a client world, along with knowledge of human development models and current best practice as common elements of therapist competency (p. 313).

Rayle (2006) described how "mattering to others" (p. 483) represents a powerful

therapist-client dynamic which strengthens the overall counseling process. The author explained how sociologists Elliott, Kao, and Grant's (2004) triadic model of mattering—attention paid by others, feeling important to others, and others' reliance on us—can facilitate a client's sense of feeling significant to the therapist and enhance the ever-important counseling relationship. Though generally didactic in nature, this article's account of empirically deduced concepts added another dimension to the discussion of essential relational attributes.

In addition, Aponte et al. (2009) reported on implementation of a course to train “the person of the therapist” (p. 381) within Drexel University's Marriage and Family Counselor graduate program. While this article also represented a descriptive account, of interest to the present topic was emphasis on the idea that

Because the medium through which we do therapy is our ‘selves’ in relationship with clients, we need training about the use of our own person—our history, culture, values, family life experiences, personal psychology, and thematic personal struggles—in the development of ourselves as therapists (p. 392).

Moreover, Okiishi, Lambert, Eggett, Nielsen and Dayton (2006) undertook a large scale, six-year longitudinal study of over 5000 clients and 71 therapists at a university counseling center to assess differences in treatment response. Of interest to the present inquiry, results indicated that there were significant differences among individual therapists' abilities to efficiently produce positive outcomes for clients.

Most recently, in a study of therapist effectiveness in providing cognitive therapy for veterans displaying the symptoms of post-traumatic stress disorder (PTSD), Laska, Smith, Wislocki, Minami, and Wampold (2013) pointed to the importance of the

individual therapist as a change factor. They identified essential therapist characteristics as a flexible interpersonal style and ability to establish strong therapeutic alliances (p. 37). The size of the participant pool (192 clients/25 therapists) and analytical rigor lends credence to these findings.

Collectively, the cited studies from the counseling literature provide evidence that this field has increasingly begun to focus on the therapist side of the relational paradigm.

### **Alliance**

A strong working alliance has traditionally been seen as the foundation for much of the change that takes place in a therapeutic counseling setting. “It is in the therapeutic relationship that therapists either make or break therapy...the strength of the relationship (in the view of the client) is a significant contributor to change...alliance is an excellent predictor of outcome” (Blow, et al., 2007, p. 309). A therapist’s ability to form a productive working relationship with clients may represent one of the most telling factors in successful therapeutic outcome.

Dunkle and Friedlander (1996) investigated personal characteristics that foster alliance in the therapy situation. In assessing clients’ perception of the early working alliance with 73 university counseling center therapists, results indicated that therapist comfort with interpersonal relationships, lack of self-hostility, and strong personal support systems (e.g., friends; family) correlated positively with client perceived alliance. While results signified that experience level alone was not sufficient for fostering goal setting or emotional bond, comfort with closeness predicted the therapists’ ability to develop an early working alliance as perceived by clients. The authors noted that this correlation appeared to support the notion that what a therapist brings to the setting

represents an important indicator of how that therapist will interact with a client.

These results aligned with client perspective ( $N = 34$ ) as explored in a phenomenological inquiry by Bachelor (1995). Analysis discerned three categories of therapist alliance and specific characteristics that aligned with each: nurturant (e.g., respectful, patient, friendly, facilitative, nonjudgmental, and empathetic), collaborative (e.g., self-disclosing, honest, trustworthy, active), and insight oriented (e.g., competent, directive, giving feedback, guiding).

Alliance with children was directly addressed by Liber et al. (2010). In a thorough, randomized multisite trial in the Netherlands, investigators compared group and individual cognitive-behavioral therapy for children with anxiety disorders to examine the relationship between therapeutic alliance, treatment adherence, and outcome. Results indicated that stronger child-therapist alliance led to greater and more reliable changes in child behavior. Though gains were most prominent within individual treatment, both group and individual conditions proffered a positive correlation between alliance and symptom improvement.

Results of another large scale study ( $N = 71$ ) of youth in residential care (Handwerk et al., 2008) also demonstrated a positive correlation between youth rated therapeutic alliance and self-reported symptom reduction. Nonetheless, overall behavioral improvement did not prove statistically significant. Questioning the therapeutic strength of alliance alone, the researchers noted that “perhaps what therapist do with children (i.e. strategies, tactics, advice) is more important than whether youth clients like their therapist” (p. 159). The authors did note, however, that due to the family setting component of this particular treatment regimen (children were housed in family-style



environments with surrogate parent figures), the importance of the therapist-child alliance may have been compromised as compared to traditional residential settings. They also noted that self-report as a measurement tool should also be viewed skeptically.

Nonetheless, the children themselves indicated a perceived importance of alliance.

Therapeutic alliance with adolescents was investigated by Martin, Romas, Medford, Lerrert, and Hatcher (2006). This exploratory inquiry with a non-clinical adolescent sample discerned 12 important alliance-forming therapist traits as rank order: respect, time shared, openness, assuming adult roles, recognition, guidance, identification, trust, freedom, likeable personality, responsibility, and familiarity. However, it must be questioned whether these results would be applicable to various clinical populations.

In an earlier study, Mook (1982) identified empathy and respect as playing important roles in child therapy as well. The researcher analyzed the verbal behaviors a therapist employed while working with two children, ages eight and twelve. Factor analysis of transcripts indicated that empathy and respect could be delineated as central to the therapeutic relationship. However, she also cautioned that therapist reliance on verbal interaction may not necessarily be the most developmentally prudent means of interacting with children since they are less verbal than adults and tend to express emotion through non-verbal means. These findings were further corroborated in the work of Zack, Castonguay, and Boswell (2007) and Eyrich-Garg (2008).

Yet, Schoenwald, Sheidow, and Letourneau (2004) found that consultation alliance alone was insufficient for improving child outcomes. This study assayed a multi-systemic protocol of clinical consultation for therapists working with children presenting

with antisocial behaviors. One finding indicated that alliance was important for maintaining therapist participation in expert consultation sessions but needed to be combined with consultant competence for the protocol to positively affect therapist adherence to treatment method and child improvement.

Overall, research into essential therapist attributes for effecting positive counseling outcomes again highlighted relational factors. In delineating the role of the therapist, these research efforts stressed responsiveness, alliance building, engagement, empathy, respect, and therapist self-knowledge as important factors when working with either adults or children.

### **The Mother/Caregiver-Child Dyad: Attuned Relationship**

Closely aligned with the findings in child psychology, child development investigations also emphasized the importance of attuned relationship for children's acquisition of skills and overall progress. Predominant in this area of inquiry was the mother/caregiver-child dyad and its influence on child learning.

In a descriptive review of the literature, Strand (2000) evinced the crucial role of parent cue attunement in the development of children's social behavior. Appraised studies indicated that either in moment-to-moment and long term behavior assessment, parent ability to attend to and appropriately match children's behavioral responses directly influenced linguistic gains as well as child compliance and cooperation levels. Attuned interactions also increased the intrinsic rewards experienced by parents, leading to higher levels of conversation and participation with their children. Children developed better initiatory and exploratory skills under these conditions. Conversely, lack of parental attunement led to higher incidence of discipline encounters and child coercive

behaviors. Moreover, these results were corroborated by Kochanska and Murray (2000) who found that “mutually-responsive orientation” (p. 417) as demonstrated by shared cooperation and positive affect was directly correlated with children’s later development of social conscience. Further support for intersubjective relatedness-affective attunement was also found in the dyadic investigation of Frey (2004).

In a large scale study of 103 mother and typically developing toddler dyads from various socioeconomic backgrounds, Kochanska and Aksan (1995) assessed style of maternal control and quality of child compliance. Analysis of multiple observations indicated that children who shared positive affect with their mothers developed internalized compliance while those lacking this connection were only responding with situational (temporary) compliance. Here again, ongoing responsive liaison (attunement) appeared centrally important to desirable long-term child development. Of particular note, this inquiry represented a departure from the small sample, limited diversity, population specific nature (e.g., blindness, Caucasian-dominant, educated) of most dyad investigations. The size and depth of this research effort affords expectation of probable applicability in a therapy paradigm as well. Moreover, in an equally large, twin study follow up, Kochanska et al. (2010) also established that secure attachment not only increased willingness in children, but was predictive of future social success and positive developmental outcomes.

Parent-child attuned relationship also played a role in vocabulary acquisition for hearing and non-hearing children. Robertson et al. (2006) analyzed transcripts of young children (ages 3-6) reading and retelling stories during shared reading with a parent to test content recall and determine if shared attention affected word acquisition. Results

indicated that attuned responding played a significant role in vocabulary recall for both groups, though children with hearing loss required both joint attention and parent scaffolding techniques to retain new vocabulary.

Additional investigations that focused on children with special needs included a study by Campbell and Johnston (2009) which assayed parent-child dyads where the child was totally blind. Results indicated that while challenging, responding to their children's needs required parents to provide clear information about the intentions and feelings of others, since blindness precludes a child's ability to discern these emotional reactions visually. For young children with autism, Brigham, Yoder, Jarzynka, and Trapp's (2010) study of 25 parent-preschooler dyads determined that parent attentional cues that maintained their child's current object focus proved more effective than cues which attempted to redirect child attention to a new object.

Lenze, Pautsch, and Luby (2011) studied an Emotional Development (ED) module (p. 153) for dyads of parents and preschoolers with depression. Eight parent-child pairs participated in 14 treatment sessions which resulted in very significant decrease in depressive symptoms (effect size: 1.28). The authors emphasized the centrality of the parent-child relationship in improving children's emotional wellness. Similarly, in a wide-scale, statewide data-based study by Robl, Jewell, and Kanotra (2012), active parent involvement, appropriate parent modelling, two-way communication, and establishment of healthy relationship were cited as imperative in reducing inappropriate social behavior of children ranging widely in age (6-17). The impact of supporting single parent or mother-led households as well as the need to address parent mental health issues was also emphasized.

Similar to finding in the psychology, counseling, and music therapy discourse, the child development literature again pointed to the importance of attuned responding and caregiver support in promoting positive outcomes in children's growth and skill acquisition.

### **Teacher Attributes**

In recent years, a great deal of emphasis has been placed on teacher effectiveness in the education literature. In response to the American government's No Child Left Behind (NCLB) mandate requiring "highly qualified" teachers (Brown, Morehead, & Smith, 2008, p. 169), school systems, administrators, and teacher educators have sought to delineate those qualities that align with effective teaching (Brown, et al., 2008). As a result, extensive effort has been placed on discerning positive teacher characteristics and teacher effectiveness. Representative entries from this plethora of research are presented here.

Numerous studies pointed to love for children, good communication skills, well rounded personalities, knowledge, preparation, and ongoing training, as well as flexibility and humor as strong indicators of teacher effectiveness (e.g., Shanoski & Hranitz, 1999; Soulis, 2009; Wong, 1994). Teachers with enthusiastic, upbeat temperaments (Barrett, 1991) and those who were tolerant, reflective, and flexible displayed more effective teaching behaviors and provided more inclusive environments for special education students (Oleson, 1997).

In addition, Mowrer, Love, and Orem (2004) employed a comparative, twin study format to assay two groups of college students' ( $N = 332$  and  $134$  respectively) top 10 teacher characteristics. Results from both groups indicated near identical ranking of most

important teacher traits from a provided list of 28 qualities as follows: approachable, knowledgeable, enthusiastic, realistic, encouraging/caring, creative/interesting, effective communicator, and respectful were selected unanimously while accessible, flexible/open-minded, confident, and understanding were designated by one group each. Determining the personal attributes that correlated with teacher efficacy represented the core focus of all these cited efforts.

A number of studies sought to determine whether being highly qualified as designated by the NCLB mandates translated into effective teaching. For example, Munoz and Chang (2008) found that teachers' years of experience, education level, and race had no effect on high school students' reading achievement. Results indicated no correlation between NCLB quality determinants (i.e., experience, education level) and student reading gains across the gamut of ninth grade teachers ( $N = 58$ ) in a large urban setting. The author cautioned that teacher quality is a complex issue and warned against using these mandated characteristics as sole hiring criteria.

In a second study by Brown, Morehead, and Smith (2008), teacher candidates in the university setting continued to rate personal attributes (e.g., empathy, enthusiasm, caring) as more important than academic ability standards as listed in NCLB (bachelor's degree, state certification or licensure, proof of subject knowledge) even after undergoing coursework training in teacher competence. Similarly, Wasmund and Tate (1988) had earlier found that warm, generous personalities were stronger indicators of child care workers' effectiveness than age, education, or experience.

Xu, and Gulosino (2006) established that focusing on the behavioral aspects of teaching, in this case the skills necessary to engender good teacher-parent relations,

represented a positive determinant of kindergarten student achievement. This comprehensive study encompassed data from 1227 kindergarten programs and lent credence to the efficacy of examining “what teachers do” (p. 345) versus the credentials they hold in determining teacher quality. In addition, Birch and Ladd (1997) earlier established that teacher-child closeness positively affected kindergarten students’ academic achievement as well as teacher ratings of children’s self-directedness and school enjoyment.

School principals’ perception of teacher ineffectiveness was surveyed by Torff and Sessions (2005). Overwhelmingly, the 242 respondents perceived the causes of ineffective teaching to be deficiencies (in rank order) in pedagogical knowledge, lesson implementation, establishing student rapport, classroom management and lesson planning. Conversely, teacher’s subject content knowledge was rated as the least important factor. Though notably subjective in nature, teacher attributes and pedagogy (i.e., actual teaching skills) were thought to strongly outweigh mandated teacher knowledge qualifications in this study.

Teaching style and disposition were the subjects of three studies. Thornton’s (2006) longitudinal, three year examination of a specialized middle school program for at-risk students illuminated aspects of teacher disposition. Even within a setting where all the faculty members were considered highly skilled and dedicated, teachers with responsive dispositions—those who embraced the role of teacher as responsive supporter—were rated as more effective by students than teachers with technical (teaching skill focused) dispositions. Of central importance to the present inquiry, this research also purported that dispositions can be taught and should be a focus of teacher educators.

Similarly, Mahoney and Wheeden (1999) undertook a study of 49 dyads of teachers and preschoolers with disabilities to determine if teacher style affected interactive engagement. Results indicated that a teacher's interactive approach accounted for a significant portion of engagement variability. Directedness was negatively associated with child initiations while affective involvement led to increased child attention and initiation. Even within the brief, two-episode observation of each dyad, a clear trend was established. Moreover, results of Whitley's (2010) large scale study ( $N = 3267$ ) showed that teachers' expectation of student achievement correlated with student progress, a fact that adversely affected students with learning disabilities. Teachers' lowered expectations and decreased confidence in their ability to instruct these students negatively influenced learning outcomes.

Walls, Nardi, von Minden, and Hoffman (2002) surveyed 90 prospective, new, and experienced teachers in an effort to ascertain what they perceived to be the top five elements of an effective teaching environment. With 97% agreement across all experience levels, the participants listed emotional environment as the most important consideration followed by teacher skills, teacher motivation, student participation, and rules and grades (p. 43). In addition, rank ordered descriptors of the effective teacher characteristics were listed as: caring, organized-prepared-clear, enthusiastic, and authentic-interaction oriented (p. 45). Likewise, results from a survey of 227 public school teachers and 14 principals conducted by Colker (2008) designated effective early childhood teacher characteristics as: passion for teaching, perseverance, risk taking, pragmatism, patience, flexibility, respect, creativity, authenticity, love of learning, high energy, and sense of humor (p. 71).



One study directly explored affect attunement in the classroom. Poulsen and Fouts (2001) systematically studied attuned (defined as trained in interactive drama techniques) versus non-attuned (traditional didactic approach) teacher style during mathematics and social studies instruction for fourth grade students with and without learning disabilities ( $N = 31$  &  $147$ , respectively). Cross-categorical analysis of videotaped sessions (e.g. learning disabilities and math; non-learning disabilities and social studies) indicated that teacher-student attunement led to greatest gains in academic performance. As also noted by Perry (2000), “the core of good teaching is attunement; that is being aware of, and responsive to, another” (p. 20).

As evidenced in the examined surveys and studies, teacher effectiveness appears to be most highly influenced by pedagogic skills. Throughout the discourse, attributes of engaging personality, supportive disposition, attunement abilities, and an empathic, flexible, caring nature positively correlated with teacher effectiveness. In all instances, personal qualities and relational abilities far outweighed technical competence, experience, or certification. These findings speak strongly to the need for personal responsiveness and relationship building capacities as tools in the arsenal of the effective child-focused music therapist.

### **Responsive Classroom**

A recent phenomenon in educational methodology has been implementation of the Responsive Classroom (RC) approach (2013). Since this method is based on relational practices with children, delineation of this approach is of relevance to the present inquiry. As described by its founding organization, the Northeast Foundation for Children (2014), RC practices are based on the following guiding principles:

1. The social curriculum is as important as the academic curriculum.
2. How children learn is as important as what they learn: Process and content go hand in hand.
3. The greatest cognitive growth occurs through social interaction.
4. To be successful academically and socially, children need a set of social skills: cooperation, assertiveness, responsibility, empathy, and self-control.
5. Knowing the children we teach—individually, culturally, and developmentally—is as important as knowing the content we teach.
6. Knowing the families of the children we teach and working with them as partners is essential to children’s education.
7. How the adults at school work together is as important as individual competence: Lasting change begins with the adult community (2014).

Classroom practices include: morning meeting; rule creation, interactive modeling, positive teacher language, logical consequences, guided discovery, classroom organization, working with families, academic choice, and collaborative problem solving (Northeast Foundation, 2014).

Though the body of research pertaining to this educational methodology was found to be generally sparse, a few studies are offered here as descriptive and empirical delineations of this approach. Bondy, Ross, Galligane, and Hambacher (2007) qualitatively studied four novice teachers’ focus on developing relationships and establishing expectations with urban African-American students through the use of “insistence” and a culturally responsive communication style (pp. 334; 341). As noted by the authors, “The teachers communicated the importance of relationship building through

their words and their deeds” (p. 334) and continually insisted on respectful behavior. As identified, teacher style and characteristics included creating a caring, task-focused, safe place for learning, expectation of student success, use of humor, and empowering children’s resilience.

Employing a longitudinal, quasi-experimental design, Brock, Nishida, Chiong, Grimm, and Rimm-Kauffman (2008) studied 520 at-risk children and 21 teachers to examine the efficacy of integrating social and academic learning (an RC approach) in enhancing students' positive perceptions of their classroom and academic and social performance over time. Results indicated these RC teaching practices were positively correlated with children’s positive perceptions and academic progress. However, the authors noted that the self-designed assessment model employed in this inquiry would require further testing and wider application.

An exploratory study conducted by Rimm-Kaufman and Chiu (2007) longitudinally examined the contribution of the RC approach over a two-year period. Findings demonstrated that teachers’ use of RC practices was associated with students' improved reading achievement, greater closeness between teachers and children, better pro-social skills, more assertiveness, and less fearfulness, even after controlling for family risk and children's previous years' performance. Family risk did not moderate the correlation between RC practices and children's performance.

Finally, Milner, and Tenore (2010) investigated the culturally responsive classroom management practices of two teachers in a diverse, urban middle school. The principles that emerged from this exploratory study included: teachers’ need to understand equity and equality, identification of power structures among students,

immersion into students' life worlds, cognizance of self in relation to others, ability to grant students entry into teacher worlds, and a conception of school as a community with family members.

Of pertinence to the present inquiry, this approach is interpersonal in manner, based on respectful relationship, child-centered, collaborative, and emphasizes teachers' abilities to foster a safe, productive environment for student learning—ideas and structures that arguably apply to productive therapeutic alliance as well.

### **Further Areas of Interest**

Two other areas of investigation proved informative in illuminating aspects pertaining to the topic of essential therapist attributes and relationship-building skills. First, the play therapy literature inherently emphasizes factors involved in working with children and highlights therapist abilities necessary to engender positive alliances with child clients. Second, since this research effort also seeks to ascertain the current status of music therapist education and training, exploring the latest teaching practices and pedagogical technique will be helpful.

### **Play Therapist Characteristics and Effectiveness**

A search of literature yielded few controlled examinations of play therapy. Bratton, Ray, and Rhine (2005) attempted to combat this research deficit by assaying overall effectiveness and factors that impact play therapy efficacy in a meta-analysis of 93 controlled outcome studies (from 1953-2000). Results indicated a positive treatment effect ( $SD = 0.80$ ) across all age levels, genders, and presenting conditions. Greater positive outcomes were evidenced in humanistic versus non-humanistic treatment paradigms with parental involvement producing most pronounced gains.

A naturalistic study by Bowers (2009) sought to describe play therapists' initiation of interaction with young children. Six themes emerged from analysis of focus group and individual meetings (live and videotaped) with play therapists from Holland and Canada: qualities, goals, description, therapeutic support, process, and indicators of growth. For the purpose of this review, therapeutic support results were extracted. Development of child narrative, sense of empowerment, increased self-actualization, and emergence of language and "voice" (p. 176) were all facilitated by the play therapist's ability to establish an early relationship with the child. Therapeutic responsiveness and supportiveness surfaced as important therapist attributes.

Though didactic in nature, Robinson's (2011) descriptive account delineated play therapy's role in the school setting. She highlighted core tenets of congruence, acceptance, and empathy as central to a therapist's interventions and emphasized non-verbal mirroring and use of expressive media as important treatment options. Morrison (2009) presented a case study which assayed Adlerian play therapy's ability to provide a child with opportunities for emotional expression and mastery over a traumatic experience. While both of these efforts exposed dimensions of the play therapy paradigm, the presented ideas were not amenable to extraction.

In an early study, Chapman (1975) compared children's (ages 7-8) responses to joke listening through headphones when alone versus when accompanied by two or three study-confederate peers. Results were indicative of a strong social component to humor since the experimental subjects' laughter intensity and duration decreased when the confederates repeatedly made glances at each other, excluding the target child. These findings point to the facilitative or inhibitory effect that mutual sharing in social

situations can have on humor and suggest an attuned relational component in children's social encounters.

Playfulness as a therapist variable was examined by Schaefer and Greenberg (1997). Data from large-scale sample testing ( $N = 104$ ) of a "Playfulness Scale for Adults" (p. 23) resulted in moderately strong construct validity (correlation of .62;  $p < .01$ ) when compared to the "Multidimensional Sense of Humor Scale" (p. 25). Pertinent to the present inquiry, five categories—fun loving, sense of humor, enjoys silliness, informal, whimsical nature—were found to be aspects of playfulness that related to effective play therapist attributes (p. 25).

Effect of adult modelling on young children's ( $N = 37$ ) pretend play was examined by Nielsen and Christie (2007). Results indicated that modelling pretend play led to increased child pretense that the authors cited as congruent with earlier research efforts. Of note, children's post-model pretending often contained novel creativity versus simple imitation. The importance of appropriate adult modelling when working with children was underscored by this research effort.

Therapist relationship building capacities were also seen as vital within clinical play therapy work. Allen, Folger, and Pehrsson (2007) noted the importance of assisting play therapy interns in building counseling relationships with children. The authors presented a three-step model designed to facilitate supervisors' abilities to help interns develop therapeutic partnerships that afforded children opportunities to understand their feelings and fostered positive outcomes. Similarly, Woolf (2012) described how training staff in attachment theory and fostering understanding of play's role in relationship building and emotional well-being resulted in improved preschooler self-esteem and

social development. Again, both of these accounts were didactic in nature.

Carroll's (2002) earlier qualitative investigation of children's opinions further supported the central prominence of relationship. Results indicated that children primarily regarded play during therapy as fun. However, participants also cited being able to explore difficult emotions within a supportive, relationship-based setting as the basis for enjoyment and progress.

Carmichael (1993) even more directly addressed therapeutic relationship in testing an instrument developed to empirically study therapist-client interactions. A hierarchal list of therapists relational responses (summarizing, clarifying statements, limit setting, reflection of feeling, open-ended statements/questions; tracking statements; silence; information giving; judgmental statements; analyzing) along with corresponding sets of child behaviors/therapeutic outcomes (resistance; silence; information seeking; exploration; rapport; emotions; problem identification; alternatives) were scored in a matrix which allowed for specific relational interactions to be identified. Though limited in scope, this preliminary effort proved successful in producing a graphic analysis of broad ranges of relational behavior exhibited in play therapy sessions. A positive correlation was noted between particular therapist responses and client behaviors which could have implications for play therapist training and supervision. However, the need for further testing of the tool precluded specification of these behaviors.

Thus, therapist relational abilities and empathic, playful, humorous presentation were deemed important to the development of effective play therapy environments. Moreover, as reported by interviewer Baggerly (2008), prominent play therapist, Garry Landreth commented,

If therapy is to occur, then I must ensure that this is a safe, predictable relationship for this child...[I] encourage all counselors and play therapist to trust the inner direction of the child and in that process also trust yourself, test yourself, put yourself under supervision, get the experience you need to become proficient as a professional therapist. Be open to learning and never stop learning.

A children's music therapist must remain cognizant of these tenets and relational factors as well.

### **Current Practices in Music Therapy Education**

In discerning the current status of relational training for music therapy students, it is necessary to examine the training paradigms and strategies that are currently being discussed in the music therapy literature. As noted by Sapyta, Riemer, and Bickman (2005), feedback is essential to the therapeutic process. Providing clinicians with in-process patient status guided practitioners in improving outcomes. It seems logical that such experiential feedback would assist in an education process as well. A number of recent investigations provided depictions of such active learning-based processes.

Barry and O'Callaghan (2008) described music therapy students' use of reflexive journal writing and analysis as a valuable educational tool to facilitate therapeutic understanding and practice insight. Qualitative analysis revealed that this process resulted in greater student understanding of such concepts as contextual influences, the connection between theory and practice, self-evaluation, and supervision. Luce (2008) examined a collaborative group teaching strategy designed to enhance students' active participation and personal responsibility for their own learning. Results indicated that, overall, this paradigm contributed to students' increased understanding of music therapy processes;



however, individual responses were mixed—some students noted the positive effects of this learning format while others criticized this method's ability to meet their personal needs.

Baker and Krout (2011) reported on a preliminary pilot study that tested the effectiveness of reflecting on clinical experiences by collaboratively writing song lyrics with a peer. The lyrics produced by two pairs of students were analyzed for thematic content which the researchers noted closely paralleled themes found in the music therapy literature. Interestingly, this effort incorporated a distance component with American and Australian students collaborating via electronic media. However, the authors noted that determining efficacy of this approach would require far wider application.

Two inquiries probed the use of experiential learning within music therapy groups. Amir and Bodner (2012) analyzed student reflections about personally participating in group role-playing processes. Qualitative analysis indicated that student responses aligned with two categories—ways of participation and styles of participation. Participation ways sub-categories included talking, playing, observing, and vocal activities while participation styles incorporated identifying with, leading, silently participating, and assuming a child role.

Conversely, Winter (2013) focused on whether experiential role-playing during music therapy group could increase students' empathy and self-esteem ratings. While quantitative pre-posttest measures demonstrated no significant effect, students described feeling more empathy and greater self-esteem after assuming therapist or client roles.

The above investigations and descriptions represent a new avenue of inquiry in the music therapy discourse that is currently preliminary and fairly sparse in its scope.

Nonetheless these offerings do showcase more active learning paradigms that are beginning to surface within music therapy education. These experiential techniques will require further delineation and testing.

### **Summary**

Examination of the music therapy literature resulted in the discovery of a general paucity of investigation pertaining to essential music therapist attributes for fostering positive outcomes with children. Quantitative inquiries provided information about the importance of supportive verbal content, nonverbal behavior, and self-efficacy while only one investigation actually assayed actual music therapist qualities. Moreover, efforts to assess personal traits remained largely focused on the demographics of future music therapists or on those qualities that fostered life-long commitment to the profession.

Qualitative music therapy investigation did more closely spotlight relational issues in the areas of affect attunement, presence, intuition, work styles, perception of effectiveness, self-awareness, and features of musical relationship. Likewise, a limited number of music research efforts addressed relational work with children in areas such as attunement to body language, joint attention through improvisation, and parent-child dyads. However, these presentations remained individualistic in nature and not intended for generalization.

Broadening the inquiry, the psychology and child development literature repeatedly spoke to the importance of positive regard, empathy, supportiveness, genuineness, responsiveness, mirroring, alliance building, and attachment in fostering effective therapist-child relationships. The counseling discourse placed emphasis on building alliance with children as the foundation for successful outcomes. Empathy and

respect as demonstrated through verbal behavior, therapist relational comfort, relying on a strong knowledge base, and making the client feel that they mattered to others were also highlighted in the dialogue.

The broad education literature offered yet another perspective. Teacher attributes such as flexibility, humor, tolerance, reflective ability, generosity, responsiveness, a sense of caring, enthusiasm, patience, respectfulness, authenticity, high energy, upbeat demeanor, warmth, and love of children were deemed the strongest indicators of teacher effectiveness. Moreover, personal attributes were rated as more important than age, experience, educational degrees, or professional credentials. The relational tenets of Responsive Classroom were also explored. Importantly, Thornton (2006) also emphasized that responsive dispositions can and should be taught while Perry (2000) denoted relational attunement as at the core of good teaching,

Investigations from the play therapy discourse were also examined. Here again, therapist responsiveness, supportive interaction, and partnership as well as playfulness, reflective mirroring, congruence, acceptance, and empathy were deemed important in engendering positive relationships and successful outcomes with children. However, it is important to note the general descriptive nature of inquiry in this area; controlled outcome as well as qualitative investigations were noticeably lacking within the discourse.

Lastly, the literature reflects a growing focus on experiential learning within music therapy training. Contributors offered reflective journaling, collaborative learning, role playing during experiential music groups, and co-writing of reflective song lyrics as potentially effective teaching strategies. These efforts remain preliminary, nonetheless,

and will require further study and refinement before evidence of educational efficacy can be obtained.

The significance of relationship in fostering positive outcomes crossed all investigated research arenas and encompassed a wide variety of settings and client populations. Qualities that promote relationship building emerged as central to effecting successful outcomes. Specifically, a therapist's ability to create a positive therapeutic alliance appeared more closely related to the personal attributes and relational capacities brought to the relationship than to delineated theoretic orientation or technical expertise.

However, the fact remains that research focused directly on music therapist relationships with children remains sparse. Delineating the personal qualities related to the development of positive music therapist-child interaction and applying this knowledge to inform the music therapy educational process remains necessary. Turning attention to the specific personal qualities that a music therapist brings into therapeutic relationship with children is warranted. The role of such attributes as personality, disposition, feelings, beliefs, intuition, insight, and authenticity remains to be clarified.

## CHAPTER 3

### Method

The intent of this study was to discern the essential personal attributes that a music therapist employs in establishing productive therapeutic alliance with child clients and to ascertain whether and how these personal qualities are currently addressed within the training of music therapy students. The nature and complexity of this inquiry dictated the application of a sequential mixed method research design:

Mixed methods research is an approach to inquiry that combines or associates both qualitative and quantitative forms...it is more than simply collecting and analyzing both kinds of data; it also involves the use of both approaches in tandem so that the overall strength of a study is greater than either qualitative or quantitative research (Creswell, 2009, p. 4).

As further described by Creswell:

Sequential mixed methods procedures are those in which the researcher seeks to elaborate on or expand on the finding of one method with another method. This may involve beginning with a qualitative interview for exploratory purposes and following up with a quantitative survey method with a large sample so that the researcher can generalize results (2009, p. 14).

During the study's initial phase, an individually applied phenomenological investigation was employed to ascertain experienced children's music therapists' ideas about the essential personal attributes and relational qualities they employed to engender productive therapeutic liaisons with children. As generally described, phenomenology is an approach that allows researchers to study phenomena, such as human experience, as

“‘unified wholes’...human experience in the world” or “lived experience” (Forinash & Grocke, 2005, p. 321). Chase (2005) speaks to investigation of these personal narratives as examining “an extended story about a significant aspect of one’s life” which focuses “not on historical events...but on the meanings that events hold for those who lived through them” (p. 652). In-depth personal interviews with five established clinicians provided narrative material for analysis of how seasoned music therapists successfully form productive relationships with child clients. The resulting data were then cross-compared to determine possible agreement or disparities across the five qualitative analyses.

To further illuminate and potentially corroborate these qualitative findings, responses from a wider sample of music therapy educators and clinical trainers was then sought during the second phase of this study. A largely quantitative survey was designed to poll this wider pool of clinicians and professors, first to determine their level of agreement with the initial cross comparison Phase One findings and to then ascertain the current level of pedagogical emphasis placed on these identified personal attributes within the training of music therapy students. “Survey research involves collecting information by asking a set of predetermined questions to a sample of people who are selected to represent a particular population” (Prickett, 2005, p. 50). As noted by Black, survey questionnaires are intended to be “instruments that reflect the strength of attitudes, perceptions, views and opinions” (2005, p. 215).

It was the researcher’s belief that the combined outcomes from these two very different investigative processes would provide the clearest picture of how development of essential personal and relational attributes as identified by children’s music therapists

is currently addressed within the general training process of all music therapy students. It should be noted that both research phases were approved through expedited review by Lesley University's Institutional Review Board (IRB) and all research protocols were conducted according to IRB standards for human subject research. A copy of the IRB acceptance letter can be found in Appendix A.

### **Phase One**

Phase One was comprised of a qualitative investigation designed to address the study's first two research questions:

1. What are the personal attributes that experienced music therapists see as essential to their ability to engender effective therapeutic liaison with child clients?
2. What are the important components of relationship building as delineated by experienced music therapists?

Phenomenological inquiry best suited exploration of these questions as they involved the exploration of individual music therapist's lived personal experiences. Creswell (2009) drew upon the work of Moustakas (1994) in describing this research method as "a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants. Understanding the lived experiences marks phenomenology as a philosophy as well as a method" (p. 13).

Phenomenology does not deal in facts, cause-effect relationships, generalizations, or speculation. Instead it aims to "transform lived experience into a textual expression of its essence" (van Manen, 1990, p. 36). For this reason,

phenomenology lends itself well to studies of complexities and mysteries of life that require thoughtful, reflective approaches (Forinash & Grocke, 2005, p. 324).

**Inquiry methodology.** Semi-structured interviews were conducted with five highly experienced music therapy clinicians who possessed long histories of success working with children. Kvale & Brinkman defined a semi-structured interview as having “the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena” (2009, p. 3). These open-ended dialogues sought to obtain rich information for in-depth scrutiny and analysis:

Qualitative interviews are conversations in which a researcher gently guides a conversational partner in an extended discussion. The researcher elicits depth and detail about the research topic by following up on answers given by the interviewee during the discussion...in qualitative interviews each conversation is unique, as researchers match their questions to what each interviewee knows and is willing to share” (Rubin & Rubin, 2005, p. 4).

Through prolonged engagement with the textual material drawn from these interviews, the researcher sought to identify salient themes pertaining to the personal attributes effective music therapists employ in forming productive therapeutic relationships with children.

**The researcher.** The researcher served both as sole interviewer and analyst during this naturalistic inquiry process. “In naturalist research, the researchers themselves become the data-gathering instrument whose skills in listening, observing, and understanding are crucial” (Rubin & Rubin 2005, p. 21). It was important to remain aware that “since the researcher is human, not an automaton, the researcher inevitably



affects what is learned” (2005, p. 21). Thus, it was imperative to delineate the attributes of this researcher and remain cognizant of what inherent biases those demographics may have implicitly infused.

Of Caucasian middle class descent with lifelong residence in the northeastern United States, the researcher held a bachelor’s degree in music education and began her professional career as a music educator. She went on to pursue a master’s degree and equivalency in music therapy and shifted her focus to clinical music therapy work, predominantly in educational settings. In addition to being a licensed music educator, the researcher possessed board certification as a music therapist (MT-BC). While her music therapy training incorporated a strong behavioral orientation, she approached her clinical work from an eclectic perspective, combining theoretic and clinical skills with her teacher training during a 31 year music therapy career.

It must be acknowledged that, similar to several of the study participants, the researcher herself was a highly experienced music therapy clinician with a lengthy career centering on servicing children in educational settings. While this factor assured both strong interest in and intimate familiarity with this type of clinical work, it also necessitated that the researcher remain conscious not to superimpose her own preconceptions about the topic and allow the participants’ ideas to take precedence. A bracketing technique was employed to safeguard against the infiltration of personal assumptions. Bracketing involves suspending “beliefs about the phenomenon being studied...let[ting] go of preconceived notions and beliefs and being fully present with the experience as it is being revealed” (Forinash & Grocke, 2005, p. 321). Holstein and Gubrium (2005) more specifically described this process as temporarily putting aside

one's own understanding and personal realities "in order to bring [a participant's] apprehension into focus" (p. 485).

**The participants.** Five veteran music therapy clinicians, four females and one male, comprised the participant pool for Phase One of this study. Participant selection was based on purposive sampling (Creswell, 2005, p. 178) applied according to the criteria of being highly experienced in working with children and representing excellence in the field. Rubin & Rubin (2005) stressed that, "interviewees should be experienced and knowledgeable in the area you are interviewing about" (p. 64). Highly experienced children's music therapist was defined as having 10 or more years of clinical experience in child-oriented settings, possessing a minimum of a master's degree, and holding either the board certification credential (MT-BC) or other recognized music therapy designation (RMT, CMT, ACMT). Excellence was defined as a history of publication, conference presentations, intern and/or practicum supervisory experience, and peer recognition of expertise on issues relating to music therapy clinical work with children.

Purposive sampling has been described as intentionally selecting participants according to their ability to "best help the researcher understand the problem and the research question" (Creswell, 2005, p. 178). This sampling method enabled selection of participants who the researcher felt were likely to provide rich information for analysis. Additionally, the interviewees were chosen to represent a cross section of music therapists working with children. Three contributors worked in public education settings—early childhood, elementary aged children with a range of special needs, and middle school students with emotional and behavioral impairments, respectively. The remaining two participant clinicians worked outside of the public school arena—one with

elementary through high school age children whose needs required private school placement and the other exclusively with children who were hospitalized.

Geographic locations of these five practitioners spanned the eastern half of the United States. In addition, both male and female contributors were included in the participant sample in an effort to address potential gender differences that could underlie responses. The ratio of four females to one male roughly approximated the proportional relationship of gender—11% male—within the music therapy profession as denoted in recent American Music Therapy Association statistics (AMTA, 2012, p. 9). By diversifying the participant sample in these ways, the researcher attempted to include “individuals who reflect[ed] a variety of perspectives...Reality is complex; to accurately portray that complexity, you need to gather ...overlapping perceptions and nuanced understandings that different individuals hold” (Rubin & Rubin, 2005, p. 67).

Each participant signed a written consent form which delineated the scope of their participation, their rights to confidentiality, and ability to withdraw at any time without reprisal (See Appendix B). All participants remained anonymous with their identities protected. Each participant was therefore assigned letter designations—ME, BR, AF, GL, & CT respectively—which acted as their sole means of identification throughout the research reporting. Collected data remained secure and protected throughout the study’s duration and will be disposed of at a later time in accordance with criteria proscribed in the consent form.

However, it must be acknowledged that the researcher was personally acquainted with all of the participants prior to their selection for this study. It was believed that this level of familiarity could potentially increase overall comfort level during the process and

afford more intimate access to the depth and richness of knowledge necessitated by the inquiry at hand.

**Data collection.** Data was gathered through individual, in-person interviews with all five participants. Each clinician engaged in a single session, in-depth dialogue with the researcher at a mutually agreed upon location. Face-to-face interaction allowed the researcher to “gather information by *observing* and by *talking with and listening carefully* to the people who are being researched” (Rubin & Rubin, 2005, p. 2). The five sessions ranged from 84-118 minutes in length and took place over the course of ten months. Follow up questions were administered when necessary via an email process as mutually agreed upon by the researcher and each of the participants.

All five interview sessions were simultaneously recorded in two formats to guard against interruption or loss of data. A Sony mp3 IC Recorder, model ICD-UX71 and a Radio Shack CTR-112 Cassette Recorder were employed for this purpose. The contents of the mp3 recordings were then uploaded to computer files. Cassette tapes were subsequently stored in a secure location to protect the integrity of the information as well as the participants’ privacy.

Each interview began with a series of demographic questions to establish factual information (e.g., age, gender, work history, years of clinical practice) as well as to set a relaxed, comfortable tone for the session. The remainder of the interview was comprised of a series of semi-structured guiding questions which sought to expose parameters of the research questions in rich response format. Spontaneous follow-up questions and probes were employed to more deeply explore areas of topic interest. As observed by Kvale and Brinkmann, “In a *qualitative research interview*, knowledge is produced socially in the

interaction of interviewer and interviewee (2009, p. 82).

Due to the depth and complicated nature of the inquiry topic, all participants were provided with the general guiding questions (see Appendix C) in advance to promote formulation of thoughtful responses that would facilitate the interview process. “The guide will include an outline of topics to be covered with suggested questions” (Kvale & Brinkmann, 2009, p. 130). Given the individualistic nature of these conversational exchanges, the actual format, sequence, and content of each interview varied as deemed necessary to ensure collection of appropriately rich data. Furthermore, insights gained from later inquiry and analysis required limited follow up questioning and refocusing of one earlier interview via email. Throughout the interview processes, the prime objective was to secure sufficiently rich and thick responses to adequately address the research questions.

**Data analysis.** The researcher began by manually transcribing recorded interview material into text format for analysis. Manual transcription allowed the investigator to remain very closely attuned not only to the interview information but the emotional context and nuance as well. To ensure accuracy of this textual representation of the interviewee’s responses, a completed transcript was provided to each participant for comment and correction as necessary in accordance with member checking methodology. Member checking involves “asking participants to compare their own experiences and meanings (as they intended to convey these to the researcher) with the way the researcher has recorded and represented these experiences and meanings as research data” (Abrams, 2005, p. 253). These textual records sought to represent the verbal responses and intent as closely as possible. However, side conversation, ancillary sounds, and typical

dysfluencies (e.g. “um,” “ah,” “you know”) as well as other extraneous sound sources captured by the recordings were omitted from the finalized copies as warranted and mutually agreed upon by researcher and interviewees.

Each of the transcripts was then analyzed discretely in sequential order in an effort to avoid any potential cross contamination of the data across the interviews. The researcher sought to identify salient ideas, elements, and emphases of each individual participant’s responses. In accordance with the qualitative research protocols of prolonged engagement and persistent observation (Forinash & Grocke, 2005, p. 359), manual coding of the content was followed by thorough and repeated scrutiny until coded meaning units and thematic material emerged. The subsequent findings were summarized and written for each interview immediately following its analysis to ensure close association with the material and in further attempt to maintain purity of the data across respondents. Upon completion of all individual analyses and write-ups, a cross comparison was then instituted to discern whether thematic similarities pertaining to the research questions or other aspects of the content were present. Those outcomes then served as the basis for development of the Phase Two survey.

## **Phase Two**

Drawing on the information and thematic content derived from the cross comparison of the Phase One qualitative analyses, a survey was developed for electronic dissemination to music therapy educators and clinical trainers. This first portion of this questionnaire sought to examine survey participants’ level of agreement with the Phase One cross-comparison results. The remainder of the questionnaire then focused on ascertaining how the music therapy education and clinical training process currently

addresses development of essential personal attributes and relational abilities in music therapy students. Specifically, Phase Two sought to answer the study's remaining three research questions:

3. To what level do music therapy educators and clinical trainers agree with the importance of the delineated personal attributes and relational parameters identified during Phase One?
4. How is the development of these essential personal attributes and relationship building skills currently incorporated into the training of music therapy students and interns?
5. Do music therapy educators and clinical trainers think personal attributes are amenable to training? If so, how; if not, why not?

**The participants.** Professional members of the American Music Therapy Association (AMTA) who self-identified as full time music therapy educators or clinical trainers were solicited for participation in the survey. In accordance with AMTA policy, a copy of the proposed survey was submitted for AMTA executive director approval in order to gain access and permission to use member email contacts for soliciting participants. As the sole national level professional organization currently representing American music therapists (AMTA, 2014), AMTA embodied a comprehensive source for identifying the appropriate participant pool for this study.

When controlled for duplication, the potential participant list included 291 email entries —119 full-time educators and 172 clinical trainers. Of the initial pool, 20 contact addresses proved inactive, three were eliminated by the researcher as ineligible due to

some form of association with the present study, and seven respondents chose to unsubscribe, leaving a total pool of 261 potential participants.

**The survey.** According to Thomas, “survey research...denotes a process of gathering information from members of a particular group using an interview or questionnaire” (2004, p. 1). Understandably, questionnaire formats vary according to the needs of the particular research effort (p. 31). Moreover, “the mode of data collection... might well depend in part on what kind of access you have to the target audience” (p. 14).

In designing surveys, Thomas (2004) also emphasized the significance of developing clearly defined “guiding question” goals which foster the creations of “clear, concise, and unambiguous objectives” (p. 6), that “guide the creation of a set of questions” (p. 13), and ensure that “you gather the information you need” (p. 13). Applying information obtained during Phase One, an in-depth survey was developed to address the following goals and objectives:

**GOALS:**

--To increase understanding and awareness of the personal qualities of a music therapist that are essential in fostering a productive working relationship with children.

--To identify and illuminate how the training of these personal qualities is incorporated into the education of new music therapists.

**OBJECTIVES:**

1. To collect evidence as to whether music therapy educators and clinical trainers agree/disagree with the accuracy and importance of previously identified attributes of effective children’s music therapists.



2. To collect information regarding where and how these attributes are identified and taught within college music therapy curricula.
3. To collect information regarding where and how these attributes are identified and fostered within music therapy clinical training internship programs.
4. To gather opinions about the necessity of and ability to instill these attributes in future music therapists.

A copy of the Phase Two survey can be found in Appendix D. It was comprised of 37 questions divided into three general sections. In addition to polling respondents' demographic information, Section I focused on discerning music therapy educators' and clinical trainers' level of agreement with previously identified essential music therapist attributes in four areas: Personal Qualities, Relational Qualities, Cognitive Abilities, and Musical Attributes. Participants were then asked to rank order their top five selections in each content area.

Section II then employed Likert Scale format questions to poll all participants' attitudes pertaining to the training of music therapist personal attributes. Developed by psychologist Rensis Likert, these rating scales "provide information about intensity, frequency, degree of interest, [or] degree of agreement..." (Thomas, 2004, p. 41). Specifically, this process typically involves "presenting a list of declarative statements and asking respondents to rate them in terms of agreement or disagreement" (Black, 2005, p. 227). Ten declarative statements were included in this portion of the survey.

Section III contained two sets of questions, one directed toward educators and the other targeting clinical trainers. Depending upon whether a participant self-identified as either an educator or clinical trainer, the survey software automatically directed the

contributor to a specific set of five or six questions that applied to their respective milieu—the Music Therapy Education process or the Clinical Training Process. Subsequently, the final two questions of the survey specifically assayed all participants' opinions about whether personal attributes and relational abilities were amenable to training and then provided an open-ended opportunity for respondents to add any additional thoughts or ideas pertaining to the research topic.

**Survey dissemination.** The researcher chose electronic survey dissemination as the most expedient and efficient means of reaching potential participants. Thomas (2004) noted that the “important advantages of using electronic questionnaires include low cost and speed of getting the questionnaires to the participants and the responses back” (p.17).

The internet-based electronic survey design and dissemination company, Survey Gizmo (2014), was selected for use in this study. This firm's software provided both cost effective and feature rich options well suited to the requirements of this research effort. In addition to attractive formatting, the automatic send, retrieval, and data analysis features were found to be most helpful. Especially beneficial was the ability to employ imbedded software logic to direct respondents to the questions applicable to their designation as either an educator or clinical trainer, potentially assuring greater accuracy of gathered responses. Additionally, this survey company provided greater perceived integrity through a mandated survey review process that was purported to further ensured that the research effort would be viewed as legitimate and response worthy by potential respondents (Survey Gizmo, 2014).

**Pilot testing.** An initial pilot test of the survey was conducted prior to full dissemination. Sixteen music therapy colleagues of the researcher participated in this

trial. Feedback was solicited about the clarity of content and logistical accuracy of the software as well as evaluative comments about the format and ability of the questions to solicit sought after information. Corrections and modifications were then implemented as necessary. This process proved most beneficial in improving the overall quality and accuracy of the survey. In addition, the pilot also afforded the researcher the invaluable opportunity to gain greater facility with operating the software and comfort with the mechanisms of an electronic survey process.

***Full dissemination.*** An invite letter (see Appendix E) which included a link to the survey was distributed by Survey Gizmo via email to all potential participants. This letter included an explanation of the topic, the purpose of the survey, the reason for the respondent's selection, a description of participation requirements, and parameters of participant consent. Three additional response reminders were subsequently sent at approximately four week intervals to those contacts who had not yet completed the survey. The final notice contained a close date for the survey. All contact attempts included the ability for a potential contributor to unsubscribe to the emails. In addition, an automatic thank you response was sent to participants who fully completed the survey.

All data collection for Phase II was situated within the Survey Gizmo website. Reports were updated regularly and the finalized data were then converted to report form and downloaded for extended examination and analysis. Survey dissemination and data collection occurred over a twelve week period.

**Data analysis.** Analysis of each section of the survey was then conducted, utilizing a combination of quantitative and qualitative examination techniques as warranted by the form of individual question responses.

Section I examination involved tallying agreement levels for each of the listed attributes contained in the four delineated attribute domains—17 Personal Qualities, 16 Relational Qualities, 14 Cognitive Abilities, and 13 Musical Attributes. The top five rank-ordered attributes in each domain were then determined by totaling the number of times a specific trait was selected by respondents as one of the top five most important qualities. Finally, an overall composite list of the 20 highest ranked attributes across all four areas was then compiled as determined by actual tally counts for all entries.

Section II analysis consisted of calculating the Likert scale ratings for each of the ten statements. Percentage level of agreement amongst all respondents was ascertained for each question. Overall respondent attitudes about the training of music therapist personal attributes were then summarized accordingly.

The individualized questioning tracks for educators and clinical trainers required that Section III results be compiled separately for each of these groups of respondents. In addition, this section's questions were comprised of a combination of rating scales, choice specification, and open ended inquiries which necessitated customized analysis of each question. A combination of quantitative tallying and qualitative content analysis was applied as necessary to assay the various types of data. Agreement level and most frequently cited responses were compiled as applicable, and a general understanding of whether and how personal attributes are presently addressed within the education and clinical training process was sought.

The final portion of Section III attempted to determine survey participants' ideas about whether personal attributes are amenable to training. Those respondents who agreed that these qualities can be trained were then asked to specifically delineate the

techniques they employed to promote this learning. Conversely, those who disagreed were asked to identify why they felt training personal attributes was not possible. The survey's final question then provided an opportunity for participants to add any additional commentary pertaining to the research topic. These open-ended, individual comments were then analyzed using qualitatively methodology. Thematic content as well as outlying ideas and thoughts were then summarized.

## **CHAPTER 4**

### **Results**

The goal of this investigation was to shed light on the essential personal attributes and relational abilities of children's music therapists' and to determine the extent to which these traits are emphasized and fostered during the education and clinical training of music therapy students. The dimensions of this inquiry were best addressed through application of a sequential, mixed-method research design. The purpose of this chapter is to review findings from the Phase One qualitative inquiry and Phase Two quantitative survey. Phase One appraisal summarizes the phenomenological analysis and cross-comparison of information drawn from interviews with five highly experienced children's music therapists. Results from the Phase Two survey of music therapy educators and clinical trainers which drew its content from the Phase One outcomes and assayed perceptions of the current status of music therapy training are then examined. Overall conclusions follow.

### **Phase One Inquiry**

The researcher engaged in individual, in-depth interviews with five experienced clinicians in an attempt to discern the personal qualities that enable a music therapist to form productive relationships with children. The richness of the ensuing discussions were illuminated through prolonged analytic engagement with the textual material and by thick description in the form of quotes drawn directly from the interviewees' commentary to provide more personal, nuanced depictions of their lived experiences.

### **The Interview Participants**

The personal backgrounds of the five participating music therapists encompassed

a wide range of employment settings and child populations. Specific demographics were as follows:

**Participant #1-ME:** ME was a board certified music therapist (MT-BC) from a mid-western city with 25 years clinical experience. Before retiring, she had worked for 13 years as an early childhood specialist in a large public school district. Initially a music teacher, ME had shifted focus to music therapy work with young children (ages 1-7). She held a bachelor's degree in music education, a master's degree in special education with a music therapy equivalency, and neurologic and neonatal intensive care music therapy designations (NMT; NICU), as well as training in autism, developmental, and play-based approaches. ME received behavioral music therapy training but described her present therapeutic orientation as eclectic, drawing upon behavioral, humanistic, and cognitive-developmental techniques.

**Participant #2-BR:** BR had worked for the past 30 years as the staff music therapist at a private school in a northeastern state where her students (ages 3-12; high school chorus) carried diagnoses of neurological impairment, autism, and complex learning disabilities. She held a bachelor's degree and board certification in music therapy (MT-BC), a master of science in music education, teacher certification, a creative arts therapist license (LCAT), and was a certified Orff Shulwerk clinician. While her training and work setting were both behavioral in orientation, BR described her personal theoretic stance as eclectic with humanistic focus. Clinically, she relied on an improvisational music framework.

**Participant #3-AG:** For 23 years, AG had worked in a large, northern mid-west urban public school system of where her caseload consisted of early childhood and

elementary school students with emotional-behavior disorders (EBD), developmental-cognitive delays, and autism. Her 35 year career also included work with adults and adolescents with special needs, as a behavioral specialist, and administratively as a qualified mental retardation professional (QMRP)<sup>1</sup>. AG held a bachelor's degree in music performance, a master's degree with music therapy equivalency, a music educator license, and board certification (MT-BC) in music therapy. She was trained in neurologic music therapy (NMT), Level 1 Orff Shulwerk, and had extensive in-service training (e.g., autism, sign language, picture exchange communication, responsive classroom, children of poverty). AG described her theoretic orientation as eclectic while drawing on behavioral music therapy training.

**Participant #4-GL:** GL, the sole male participant, had maintained a 17 year public school practice (10 elementary/7 middle school) in a middle Atlantic state where he also directed a national roster music therapy internship program.<sup>2</sup> His caseload was predominantly comprised of students with emotional disabilities and autism. GL held a bachelor of fine arts, a master of arts with board certification (MT-BC) in music therapy, and a creative arts therapy license (LCAT). His 27 year career also included work in residential psychiatric and children's medical or psychiatric settings. Though trained behaviorally, GL cited an eclectic theoretical stance which included cognitive-behavioral methodology, Applied Behavior Analysis (ABA), Object Relations Theory (Kernberg, 2004), and a working knowledge of psychodynamic transference and counter-transference. Clinically, GL relied on musical improvisation.

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<sup>1</sup> It should be noted that this terminology, though outdated by present standards, was prevalent at the time this position was held.

<sup>2</sup> Music therapy internship training programs sanctioned by the American Music Therapy Association. These programs are overseen by AMTA and are required to follow set guidelines.



**Participant #5-CT:** CT's 19-year clinical career had centered on innovative music therapy work with children at two large southern metropolitan medical centers—a burn center and a children's acute care hospital specializing in complex and rare diseases. Her focus areas included trauma and emotional-physical rehabilitation; she also directed a national roster music therapy internship program. CT held a bachelor's degree in music therapy, a master of science in counseling, a professional counselor license (LPC), and training in NMT and Health Rhythms™. She described her theoretical orientation as integrative with reliance on cognitive-behavioral, humanistic, and child-centered approaches—drawing from multiple the frameworks (i.e., Maslow; Piaget; play therapy; child development; knowledge of brain function; music's effect on the brain).

### **Interview Analysis and Theme Development**

The researcher first identified units of meaning within the transcribed interview data. Repeated scrutiny and prolonged engagement with the material exposed redundancies, similarities, and connections that gradually led to aligning the data into theme areas. A description of thematic identification for each interviewee follows:

**Participant #1: ME.** Preliminary analysis of ME's 84-minute interview transcript produced 42 identified meaning units. In-depth analysis allowed the researcher to organize these meaning units according to the following themes: the music therapist (16 units); the child (9 units); the therapy work (7 units); and the music (2 units), all of which surrounded and supported the relationship (8 units).

**Participant #2: BR.** Fifty-nine meaning units were initially drawn from BR's 98-minute interview transcript. Repeated scrutiny resulted in aligning the content into five themes: the educational setting (3 units), working with children (18 units), the music (4

units), and the music therapist (17 units), which all support the relationship (16 units).

**Participant #3: AG.** Analysis of AG's 118 minute transcript produced 57 meaning units which ultimately aligned with the following themes: work in schools (8 units), the school-age child (13 units), the music therapist (17 units), the music (4 units), and the relationship (15 units).

**Participant #4: GL.** Close examination of the interwoven content of the 75 meaning units initially drawn from GL's 92 minute interview transcript led to reducing these groupings to 59 working codes that aligned with the following themes: the students (12 units), the music therapist (23 units), the school setting (6 units), the music (5 units), and the music therapy relationship (13 units).

**Participant #5: CT.** CT's 114-minute interview transcript initially produced 81 meaning units which upon closer examination were condensed to 59 working codes. In-depth scrutiny exposed connections and associations that led the researcher to align the material according to the following themes: the music therapist (19 units), the music factor (5 units), the hospital setting (8 units), hospitalized children (6 units), and the relationship (21 units).

### **Components of Establishing Relationship**

Each participant described the music therapy relationship as grounded upon four foundational components which could be generally categorized as: the music therapist, working with children, settings for the work, and the role of music. The fact that these relational foundations appear to have remained constant despite diversity in the participants' specific therapeutic emphases, personal styles, clinical orientations and setting considerations warrants more thorough rendering. The clinicians' commentary

pertaining to each of these themes will be presented using a combination of analytical findings and thick description in the form of direct quotes. A discussion of their views about forming relationships with children then follows.

*There was this music therapy journal article a couple years ago...  
about long term music therapists. The ones who stay in it  
have the ability to see things as positive or special,  
and kind of feed themselves on that and self-correct.  
I found that really telling and helpful. (AG, 2012)*

**The music therapist.** The central role that participants' indicated the person of the music therapist plays in fostering productive therapeutic alliances with children was clearly portrayed by the 92 meaning units collectively aligned with this theme area. As BR noted, fostering relationship with her students involved placing herself, "the person of the therapist," into the association. Nine sub-topics were identified during analysis of the interviewees' discussions of themselves as therapists: musician + therapist; passion, commitment, and personal satisfaction; eclectic orientation; the role of experience, supervision and support; remaining a learner; self-awareness, authenticity, self-care, and validation; maintaining boundaries; appreciating challenges; personal qualities and therapist style.

***Musician + therapist.*** The concept of being a "musician + therapist" surfaced during three of the dialogues with this duality portrayed as central to the ability to access music in the service of others. ME described herself as "not a performer" but feeling "very comfortable using music to enhance the therapeutic relationship." GL noted that music's role transcended that of a tool or strategy: "I've really learned to trust the music

as my co-therapist.” CT stated that being a music therapist involved combining her entity as a musician with the therapy process. This quote highlighted the perspective that being a musician brought to her work:

CT: I think we use the music. I think it comes from the person first. For me...it comes from within...it comes through me...I think you know the music is the expression of me.

***Passion, commitment, and personal satisfaction.*** Professional commitment and the personal satisfaction derived from music therapy work proved to be another salient sub-topic drawn from the discussions. GL spoke about his enthusiasm and commitment to music therapy work: “Twenty-seven years in the field and I still think sometimes—this is it! This is still what I want to do.” ME highlighted how providing music therapy services held inherent meaningfulness for her: “It’s like a self-actualization and a professional actualization all in one.” CT stated that feeling part of something bigger than herself contributed to her personal sense of worth and self-actualization. AG’s quote illustrated the personal satisfaction she derived from helping students:

AG: I’ve been doing this for a long time, but, what still jazzes me and makes me want to talk about it are those people where I feel like—I made a real difference; something there that I gave them, something that I hope they can take or use for the rest of their lives.

***Eclectic orientation.*** GL’s comment exemplified the behavioral methodology that all five participants cited as the basis of their music therapy training:

GL: In my undergraduate work, I don’t think we ever uttered the word improvisation. It was a very behavioral program. I remember going into

practicum and assessing affect by counting smiles.

Over time, however, each had come to identify with more eclectic approaches. BR described melding behavioral, cognitive-developmental, and humanistic techniques as necessary to effectively meet the needs of her students and setting. CT commented:

CT: I definitely would describe my approach as integrative...a cognitive behaviorist that's really...tied in with the humanist...[while] I do look at behavioral indicators in looking to see if what I'm doing is effective, my underlying base is person-centered.

However, GL alone emphasized the importance of understanding the effects of psychodynamic transference and counter-transference, especially, he noted, when dealing with emotional dysfunction.

***The role of experience, supervision and support.*** A third sub-category drawn from these clinicians' self-perspectives were the various roles that experience, professional support, and supervision played in promoting self-confidence and appreciation for the therapeutic alliance. AG explained that experience had enhanced her flexibility in dealing with students and acuity in "catching the moment and knowing it's of value." Time and experience, CT said, had taught her to rely on the process and her connection with children, "Trusting that the...patient will let you know where they need to go." ME cited the confidence that professional maturation afforded: "You learn to be less threatened; You can say, 'Well it happens.' Maybe the day needs to go differently and it's okay...that's not okay when you're first starting out; you're thrown by that."

GL and BR highlighted the role that supervision and collegial support had played in their professional development. BR spoke about drawing on her colleagues'

knowledge and the need to remember that “we’re not in this alone.” GL stressed, “The willingness to respond to supervision I think is just critical.” He offered an apt summative comment:

GL: I think it’s through supervision, through experience, through professional growth, continuing education...all of those kinds of things. I really feel like I’m much more qualified to open some doors... [I] have more tools.

***Remaining a learner.*** Observing, “I’m not perfect...always learning,” CT exemplified the third sub-concept of the music therapist theme: ongoing learning as a vital element of maintaining productive alliances with children. BR described herself explicitly as “the learner in this relationship” when attempting to decipher student behavior: “What’s going on with their sensory system? Is it overloaded; is it so disorganized?” AG spoke about the need to “figure it out” in analyzing her approach: “What do I need to do differently next time?” GL explained that he preferred to operate from the stance of “I don’t have all the answers.” ME highlighted the importance of keeping an open mind and cautioned against “thinking that you know it all.”

***Self-awareness, authenticity, self-care, and validation.*** The fourth delineated music therapist sub-topic centered on the participants’ different views about self-understanding, authentic presence, a self-care focus, and personal validation. BR stressed the need to address personal issues you as the therapist brought to the relationship:

BR: If you come in with your own issues—and we all do—be willing to deal with those and recognize how that might be affecting [the situation].”

CT and GL highlighted the importance of being authentic and honest when dealing with children. GL stated, “I’m not going to lie to them” and cautioned against being overly

circumspect since withholding information could undermine relational integrity. CT cited the need to “be who you are and don’t pretend that you know things that you don’t” and stated her belief that a clear sense of self lay at the core of personal authenticity:

CT: If somebody doesn’t have that self-awareness or...self-security...then how can you be genuine, if you’re not comfortable with who you are?

Three participants spoke about self-care and validation. BR observed that she needed to physically protect herself against students’ “impulsive and aggressive” tendencies. ME cautioned against setting unrealistic personal standards: “I’m very hard on myself. I expect perfection out of myself; I expect to be at the top of my game all the time.” Noting that recognition was often lacking in the music therapy profession, CT explained, “You have to get the validation from [knowing] that you’ve made a difference... and you have to find that within you.”

***Maintaining boundaries.*** The ability to separate personal from professional identity and establish clear interpersonal boundaries surfaced as another salient aspect of the role the person of music therapist plays in creating therapeutic connection with children. Two participants spoke about the importance of separating the self from the therapist. BR cautioned against “tak[ing] things personally” while GL’s quote exemplified the need to separate actions from identity:

GL: I think it’s a sense of strong ego...Sense of self. Not egotistical. It’s ego strength that, I may have gotten it wrong. That doesn’t mean I’m a screw up.

CT stated that maintaining appropriate distance enabled her to “be more of the constant calm. I’m not here to get involved...whether it’s pain or the drama of the situation.” Yet, GL noted that the “line of separation between therapist and client...sways

a little bit” and cited the importance of knowing “where you are and ...especially where the student is.” He also stressed the need to safeguard against potentially detrimental expectations (“We need to recognize that I am not your father.”) However, the following quote exemplified AG and CT’s recognition that close connection with children often prompted strong feelings that needed to be honored:

CT: You always have to keep your boundaries in check...but... some of these kids that I’ve worked with for a long time; I...really have a genuine love and caring for them.

***Appreciating challenges.*** The concept of welcoming the challenges that working with children presented evolved as the sixth sub-topic of commentary about the person of the music therapist. ME cited the “fascinating” aspects of working with “incredibly rare syndromes.” BR noted that her continued desire to do this work stemmed from the fact that it’s “challenging, in a fun way, to work with a child who’s emerging.” AG depicted her favorite students as “somebody who’s a bit of a challenge” and explained why these children appealed to her:

AG: The kids I like to work with are the ones that...people don’t think really you can; because you can! There’s something they like and want to do...I’ve worked with a lot of kids who were nonverbal or not making progress...and those are the ones that are really exciting...because they’re in there somewhere and they just need a hand to come out.

***Personal qualities and therapist style.*** The personal qualities and differing approaches that these clinicians employed to foster relationships with children were the subject of much discussion and emerged as the final sub-topic in this area. The



participants' self-portrayals highlighted a range of therapeutic styles.

AG described herself as positive, approachable, and hands on in supporting children's individual needs: "I give hugs; I give contact. I just think you can't rule out any one thing." She cited the need for flexibility: "Just because it's the plan, you don't have to follow it." ME said she strove to be open-minded, accepting, empathetic, and to "see the beauty in the world through the child's eyes." CT stated that being "kind of gentle in my approach, not overbearing" aided her in connecting with children. She also emphasized her energetic, positive nature ("I don't like to just sit and be still") and "definitely improvisational and spontaneous" style.

In contrast, BR and AG's comments underscored a reliance on the structure, consistency and predictability that both felt was essential to their success. BR stated, "I might change the activities within that routine a little bit, but it was always very predictable." AG highlighted stability: "There's a format and a structure. I'm not going to suddenly be over here, over there—I'm predictable."

Two participants preferred a guiding rather than authority role in the relationship. CT described her style as "being more of the listener than the director" while GL commented:

GL: I think my style is one of...starting off as the leader of the group. But when I sense that...group cohesion, backing off and letting the group lead itself. So at that point, I see myself as more of a guide for the group, rather than the leader of the group.

Humor and playfulness figured prominently for three clinicians. AG cited humor as an important tool ("I like to try and tease them, fool them") while CT described her

“playful” style: “I like to have a lot of fun at my job. I like to smile; I like to laugh.” This quote from BR portrayed how she often relied on props and silliness to engage her students:

BR: I can be quite silly at times...I put on a lot of hats...I put on all the clothing...I do look a little goofy. So my silliness is more visual...I’m not embarrassed by that at all.

The personal qualities and approaches highlighted by the participants demonstrated a range of clinical styles. Nonetheless, they all sought to employ themselves as therapists to engender productive therapeutic connections with children.

*I think...the older that you get...it’s like a developmental phase...*

*There is definitely a sense of security and confidence that you develop that you don’t have when you are in your twenties. CT (2012)*

**Working with children.** Working with children surfaced as the second major component of forming productive therapeutic relationship. The total of 58 meaning units aligned with this area accentuated the importance these clinicians ascribed to considering the children. The participants spoke extensively about how they worked to meet the needs of various types of children. Four sub-topics were associated with this theme area: the young child; school-age children; children in specialty settings; students with autism or emotional disabilities. However, to remain focused on the topic of essential attributes and relational abilities, only brief excerpts of these comments are presented here.

***The young child.*** ME and CT provided the majority of the discussion about young children. In creating relationship with very young children, ME stated that it was vital to keep in mind this age’s “openness, changeability and joy,” recognize that “one

size doesn't fit all," and remember that "they're kids first, and they're a diagnosed entity second." CT spoke about the need to provide very young patients with social opportunities to support their well-being and ameliorate the isolation and negative effects of hospitalization. A quote from ME's exemplified the child-centered view accentuated by these two clinicians:

ME: Everybody is like a snowflake...they're all unique. I think each child brings...that special spark that is the child; that is the individual.

***School-age children.*** AG, GL, and BR provided education-focused services to a variety of students with special needs in school-based programs. AG described how fostering positive relationships with elementary students empowered them to "find where they are really going to be good." She underscored the importance of structure and patterning, which in her opinion, provided the security and stability children needed to learn: "I believe in pattern and structure... until you build it, you can't change it." However, she also accentuated the flexibility necessary to accommodate individual needs: "You've got to have consistent rules, and at the same time, different criteria for each person."

GL and BR both cited the importance of involving older students in the decision making process: "What can we accomplish that you need to accomplish today?" (GL) and "Where should we start? You empower them in different ways" (BR). With adolescents, BR stated that her focus shifted to social skill development:

BR: They are really, really learning to interact with each other...the reciprocity, saying "Hello, how are you?" within the context of the song...shaking hands,

passing things out to one another, choosing a partner, working together as a partner.

However, GL noted that social situations often proved problematic for his students:

“Middle school students want to achieve and want to belong. And for the students with special needs... their disability gets in the way.” BR stated that her ultimate goal for older students was to build functional skills and interests that afforded life-long success:

BR: We want them to become a part of the community...and how can music and the arts continue to be a part of and enrich their lives? I feel I have a role in that...giving them those skills to help them to access the community.

*Children in specialty settings.* BR and CT described how working with children whose high level needs compelled specialty outplacement or hospitalization presented different challenges. BR accentuated the need to “be respectful. I’m not going to get in their face” and stressed that working with these students required great finesse:

BR: There’s so much in their environment that they can’t predict and that they don’t trust. If I’m too imposing, they are going to withdraw...so I have to be very sensitive.

She observed that a flexible approach allowed her to provide students with a positive and respectful environment that fostered success. Regardless of goals or interventions, she explained: “a child always has to come first...you honor their choices; you reserve judgment.”

CT stated that establishing therapeutic alliance with children in a hospital setting involved downplaying power inequities (“try to be at their level”), “asking a child’s permission,” and “giving that control to somebody and not taking advantage of the

vulnerable situation that they're in." She stressed her need to remain highly flexible, individualistic, and sensitive in approach" "Depending on the child...there are times that I have to be at a distance." CT also spoke about how participatory music groups (i.e., jam sessions) promoted vital social interaction for teenage patients: "That kind of bond you get...being in an ensemble."

Both clinicians accentuated a child-centered focus as central to their therapeutic process. BR described her approach as "shaped by what the kids are bringing in" and explained that her strategies focused on "taking their lead...giving them ownership of what we're doing." CT commented, "It's much more effective and meaningful that this is all about the child and what they're doing." She stated her ultimate objective for children in a hospital setting: "Bringing joy to their day...That's what I strive for!"

***Students with autism or emotional disabilities:*** In working with children on the autism spectrum, BR stressed that it was important to recognize the slow, gradual learning process involved and the potential effects that all facets of the environment could have on these students:

BR: He's very sensitive to the environment; if he's agitated; if there's a faucet running down the hall, I have to be very cognizant of what's going on with him and in the environment.

In his autism program, GL explained that he employed musical connection and a group format to promote relational skills: "Many of us, if we're confused about what to do, we look around and see what other people are doing. And they don't...So it's social learning that I'm encouraging."

When dealing with students who struggled with emotional issues, GL and AG

both focused on adaptive functioning. AG stressed valuing and respecting these students: “How do you help people save face? ...cause half of your behavior problems are saving face, especially with my EBD guys.” While noting that group situations were often difficult for pupils with emotional disabilities, she observed that a music-based group framework often proved effective in fostering social connection and alliance. GL highlighted the importance of empowering these children to make decisions and set goals for themselves. This statement denotes the importance he ascribed to being a stable presence for these children, regardless of transference or counter-transference tendencies, a need to test adults, and pervasive trust issues:

GL: I’m not going to leave you; I’m not going to let you push me away. I’m going to stay here because so many people have left you. [You’re] going to push people away before they can read you. But, I’m not leaving. So you better get used to me.

Ultimately, the overarching goal identified by all these clinicians was to establish the productive relationships necessary to foster children’s progress and growth.

*My life has been so rich; that’s why I keep doing it! What better gift?*

*To be able to impact someone’s life...even in that small way;*

*...just be a piece of what’s helped that child become*

*a contributing member to the society. (BR, 2012)*

**Settings for the work.** Analysis of the data revealed that the settings where the clinicians worked comprised the third foundational element of engendering productive relationships with children. A total of 32 meaning units were collectively aligned with this area. Their work environments varied according to the children’s ages, needs, and reasons for music therapy intervention. Five sub-topics were identified: early childhood

intervention; working in school settings; the hospital environment; working with families; staff, team approach, and collaboration. Again, to maintain focus on the inquiry topic, only brief excerpts of the commentary will be included here.

***Early childhood intervention.*** In providing early intervention services, ME traveled to several locations daily to work with young child and parent-caregiver dyads. She described her strategies as consistently focused on developing the “whole child” and integrating very young children’s “functional life skills” through a play-based, relational approach. ME explained that working with young children involves “frenetic pacing,” being “up close and personal,” adapting to “changes at the drop of a hat,” and varying techniques to “see what’s inside.”

***Working in school settings.*** AG, BR, and GL described their school-based settings as focused on educational outcomes and goal-driven intervention. Schedules and structure were integral components of this work. AG remarked that success within a team-taught, inclusion model depended upon her flexibility in adjusting to various classrooms and settings:

AG: [As] a music therapist in the public schools, you are in and out of other people’s rooms...I still do my own thing, but I’m a guest in that room and I have to respect that.

To effectively engage children, she described how she relied on an “activity versus intervention” format which alternated familiar, comfortable activities with more challenging interventions:

AG: An intervention is you’re doing it for a therapeutic reason and you have a different outcome. You want the student to be somewhere different when you’re

done...to have acquired a skill, an ability to wait, a focus. You are really watching for and trying to catch that moment and reinforce...to make sure the client gets it.”

The realities of working within a middle school alternating-schedule format (short vs. long period blocks), GL commented, necessitated flexibility but also afforded opportunities to involve his students in the decision-making process: “I like them to establish a goal for themselves; for the time period we are going to be together.”

To create a positive learning environment, BR observed that she designed her routines to be “always very predictable and supported and well reinforced.” She highlighted the importance of considering the structural elements and offered an encompassing definition of environment:

BR: When I think of the environment, I think of the chairs and I think of the materials I’m using. I also think of the melody and the rhythm and the form and the timbre...all of those things that I use prescriptively to help my students grow in the areas of cognition and social management—it’s all relevant.

***The hospital environment.*** CT observed that the intense, one-on-one format of hospital work resulted in small daily caseloads, required flexibility, and necessitated a range of intervention options commensurate with the diverse patients and settings. The following quote exemplifies the fluid, spontaneous, unpredictable nature of hospital work:

CT: It kind of goes with the medical setting environment because I don’t always know when I go in that day who I’m going to see because...except for group, you cannot schedule any of your sessions. [For instance] The PT says, “Hey is this



child on your list today? This is one of the kids you need to be seeing"...Then I get paged and it's a patient on the 10<sup>th</sup> floor who just got re-roomed and "They're asking for you."

CT did note that her group sessions were "when I'm probably the most structured...I definitely have a session plan." She also stressed that it was imperative to maintain accurate documentation in a hospital setting: "I had it ingrained in me, that if it's not documented, it never happened."

***Working with families.*** Both CT and ME's work directly involved children's extended families. ME stated that an important working with very young children centered on facilitating parent-child relationships—assisting parents not only to understand and support their child's development but to form positive bonds by accepting the children they had:

ME: If we can give the parents some strategies to make them feel good not only about their children but their parenting, that's a gift.

CT remarked that family involvement was a unique and important aspect of working with children in a medical setting, noting that her interventions often focused on helping parents assist their child through the hospital process. She cited the importance of "instilling hope" for families of very ill children, treating the child as a person, "not just coming in and checking their vitals and talking over them," and basing her services on what the parents felt was needed:

CT: So, what are you working on at home? What would you like me to help her with while she's back in the hospital again? So what can I reinforce?

CT's comment about "really responding to the cues I get from the child and the

family...that's the biggest thing" exemplified the manner in which these two clinicians worked with children and families.

***Staff, team approach, and collaboration.*** The importance of establishing good working relationships with colleagues was a topic that arose during all of the interview discussions. While various merits of a collaborative approach were cited (e.g., benefits for the child, ability to gain information, personal fulfillment), of present interest were the interviewees' comments about establishing collegial relationships. ME acknowledged that collaboration required a non-territorial stance in sharing techniques and information: "I feel very comfortable sharing it with the OT, PT, Speech... especially the parent, the teacher" because "we need to be team players for the good of the whole child." BR stressed:

BR: You don't want to isolate yourself. ..I really want to address the needs of the entire child...I can't do that on my knowledge base alone...be able to use the resources I have.

AG emphasized that establishing supportive connections by working closely with colleagues had a direct effect on her ability to access and effectively serve children: "I need to have Felicia like me and respect what I do...and still serve the children in the way I feel is appropriate." CT offered a story about how successful collaboration had resulted in a physical therapist's advocacy for music therapy: "I'm going to bring my 'secret weapon;' that's what he calls music therapy!" A quote from GL exemplified how creating respectful and positive relationships with colleagues and administrators by being a team player and educating others about the efficacy of music therapy generated the trust and freedom that enabled these therapists to effectively address children's needs:

GL: If I didn't have that level of support and that level of "I trust you as the music therapist to do music therapy right," I might not get to do some of what I'm doing...I never feel like I have to worry about what they're going to think about what I do.

Ultimately, these clinicians sought to establish environments and supports that fostered productive relationships with children.

*When I think of music therapy, I think of a relationship  
...between the student and the therapist that's shaped  
by the elements of music. (BR, 2012)*

**The Role of Music.** The role that music played in effecting positive therapeutic outcomes represented the final foundational component of relationship-building with children. An enduring personal and professional connection with music was highlighted by all participants. Though only 20 meaning units were collectively aligned with this domain, it must be noted that extensive content was contained within each of the five identified sub-topics: passion for music; the power of music; music in a child's world; music's role in therapy; musical relationship.

***Passion for music.*** The interviewees' deep connection and unwavering commitment to music was illustrated by this quote from ME:

ME: It was something that was mine...something that was unique to me...I could get lost in my own little world and I could escape if I could go sit down and play the piano...it was how I got in touch with my inner being."

The participants offered numerous examples of how their relationship with music informed their work. GL described how his improvisation skills allowed him to connect

with students. AG spoke about applying her music to create opportunities for children to “feel successful.” CT noted a correlation between her affinity for ensemble playing and her decision to pursue a relationship-oriented music therapy career: “I’m a violinist and I love chamber music; never liked soloing; always liked playing in an ensemble.” BR explained that she even thought about her therapeutic interventions in musical terms (“The form of what we were doing—it was ABAB.”) ME and CT spoke about the integral effect music had on their work:

ME: I think it completes us and takes us from being...technicians to be people, to be individuals, to be compassionate, to be more whole.

CT My musicianship part of me is important. Part of being a music therapist is being a musician. It comes from within; it comes through me; the music is the expression of me.

***The power of music.*** The participants’ various descriptions of music’s therapeutic effectiveness with children demonstrated their respect for and deference to the power of their chosen medium. BR described music’s capacity to foster “that engagement, that communication” which she affirmed “becomes very...magical!” In ME’s opinion, the ability to “take us places that are beyond reality,” and create physical or emotional attunement made music a powerful and motivating tool to enhance young children’s experiences. According to AG, the power of music-based programming was that “it’s directed, but it’s... music directed!” CT highlighted music’s ability to assist her patients by taking “something that they’re going through that’s difficult and make it a little bit easier on some level.” In conveying his sense of music as his “co-therapist,” GL commented:

GL: The music gets them where they need to go. Sometimes the music is the guide; sometimes the music is the container. The music can hold someone in the moment.”

***Music in a child's world.*** The idea that music represented a compelling medium for children was another sub-topic that elicited much discussion. Observing that “music and children fit together naturally,” ME stated, “I’m just a firm believer that music permeates all aspects of a child’s world.” She stressed the importance of introducing “children to all different kinds of music...exposing and broadening their world.”

BR observed that songs or instruments provided persuasive cues for children: (“the drum signals everybody to get up and play together.”) CT spoke about combining music with age appropriate play “because that is the child’s medium” and emphasized how active music making offered motivating rehabilitative opportunities:

CT: There wasn’t much movement she could do. We had this pedal that she could...push and make a sound like a bass drum; and with her other hand, we wrapped a drumstick and we had a cymbal...so she was able to have two sounds.

Several participants spoke about the need to consider children’s musical preferences. For instance, GL remarked that older student tended to prefer “guitars, drums...rhythm instruments” while BR stated, “the songs that they like [are] the more popular music.” However, ME also cautioned against assuming children’s preferences and noted that “a real hard lesson to learn was that every child may not love music.”

***Music's role in therapy.*** The participants offered diverse examples that illustrated the multiplicity of music’s roles as a therapeutic agent: as a setting event (e.g., a chime tone to elicit attention-ME), to support academic objectives (numbers; vocabulary-AG),

physical structuring (aligning pianos for eye contact-BR), eliciting group cohesion (CT, GL, AG), improving social interaction (play and pass activities-AG), increasing sensory tolerance (CT, AG, ME), and fostering self-esteem, resiliency, independence (AG; CT; BR).

ME depicted music as “a natural tool; it’s more than a tool—an enhancement to what we do.” She explained, “Sometimes that song is just [adding] some balance to life or to the experience.” GL spoke about music’s ability to engage students “in the moment,” hold intense emotions “so they can feel what they need to feel,” provide stress breaks (e.g., jamming on guitars), or generate a sense of success. He cited music’s communicative potency and ability to act as a catalyst for personal insight:

GL: He could really express what was very secret without words; everybody else wanted him to talk. The words were in the way! ...He said, “I really felt like the piano was my therapist.” And I said, “What do you think you and the piano worked through?” And he started sharing what he was angry about, why he didn’t feel like he could tell anybody.

Nonetheless, CT offered concerns about recognizing when using music is inappropriate:

CT: And sometimes it means not having music and having silence...what’s really important is knowing when not to use music when you’re a music therapist.

***Highest quality music.*** Strong musicianship and quality music were cited as cornerstones of effective music-based intervention during several discussions. ME stated that using the “highest quality music, the best we can find” was essential to all music therapy work. AG illustrated this point in a story about using classical music (i.e., Bach) as the basis for her “pizza song” activity. GL’s analogy illustrated the importance these

clinicians placed on musical quality:

GL: Walking in with something that's other than your best music is like a surgeon walking in with a scalpel that's not sharp. Why would you do that?

For some of the participants, quality music equated with "live" or improvisatory music. BR cited the unique connection possible within an improvisatory mode: "That engagement, that communication becomes very magical!" GL related how he was able to flexibly address the immediate needs of students who struggled with emotional issues by engaging them in musical improvisation. Commenting that it's "definitely reciprocal...you can't do that with recorded music under any circumstance. It will never have the same effect... ever," CT offered a rationale for her live music preference:

CT: I always feel like I'm not a music therapist if I have recorded music on...it's like this unsettling feeling. Part of being a music therapist is being a musician. So I think it's that feeling I'm not using my musician part of me! I'm using the therapist part of me but I'm not able to integrate it.

However, she did noted instances when recorded music was warranted: to deliver authenticity outside her expertise ("I'm not a Rapper"), to support movement activities, and to meet specific therapeutic needs:

CT: The recorded music has that predictability that the live music will not; for certain brain injured patients, it's easier for them to process...and I can do some hand over hand.

***Music for learning.*** All five participants spoke about using music as a catalyst for learning, which AG described as a central focus when working with children. They offered multiple examples of imbedding educational goals and objectives within music-

based programming and stressed the efficacy of supporting their interventions musically. ME emphasized music's ability to accommodate "very different learning styles," provide a pleasurable medium for the "repetition, repetition, repetition, repetition" necessary for young children to internalize information, and enhance their understanding:

ME: They may not remember what the words are of the song, but if it's what you always use when it's time to go home, it'll set the expectation; be an auditory cue

In speaking about "the simple joy of discovery," CT related an encounter with a young girl: "She takes my guitar and she just starts strumming; she had no idea about the guitar ...but she's just beaming!"

AG provided examples of using music as a nonverbal catalyst for participation ("Music starts and we just move") or increasing the complexity of demands:

AG: The drum's was a littleeee farther away...and it's further away...so you gotta move to the drum...and eventually, you've got to raise your hand if you want to drum.

BR and GL spoke about enhancing language acquisition. BR remarked that "movement really encourages language" and "helps organize kids so they're able to focus and attend." The following quotes depicted how BR and GL employed songwriting or musically adapted social stories to provide instructive guidelines for adolescents or students with autism:

BR: So we wrote this blues song...and we described the if-then scenarios: If I hit, I'm gonna lose the trip...if this happens, then that happens...we just put that all in a song.

GL: The social story with sometimes modifications becomes the lyrics to the



song...take out some of the words...so that the student fills it in...use fewer and fewer words...less and less of the song to where there's usually one instructional sentence—this is what you do! We start fading the music, then... humming that melodic line can be enough of a reminder for them to do the social story.

Ultimately, the varying music-based instruction techniques cited by these clinicians consistently focused on goal attainment and children's growth.

***Musical relationship.*** Much of the discussion about music's role in fostering productive alliances with children centered on the sub-topic of musical relationship. ME explained that consistently providing interactive musical experiences expanded young children's social awareness. GL remarked that musical and verbal communication were both important: "The music might come first or the words might come first. One leads to the other, and then I can understand and accept why you are feeling that way, why you have brought that here." AG's story illustrated how connecting through the music helped her reach students with challenging needs:

AG: I took my harp and I took tone bells the first time I saw him. I'm playing, and he's [signing] "more, more." And I said, "Well, you hold this for me first;" so he's holding the bells. The OT said, "Well, don't you want him to play them?" "No. He's holding them and I'm playing the harp. He puts them down...I stop playing. That's enough for today."

BR spoke about her obligation to remain focused on children's musical needs:

BR: I have to remind myself to find the music in the child and to connect with the music in the child...and not try to offer it...not try to make it my [agenda]...I'm going to be with him in the music...It's easy to violate that...if your goals and

your expectations take precedence in the relationship.”

The participants’ emphasis remained, as BR described, “all about the music” and their ability to harness music’s therapeutic potential to assist children. CT offered a musical analogy for establishing alliance with children:

CT: When you’re working with a child, just not go too fast or too slow...like maintaining your tempo. I guess...finding the right tempo; keeping that going.

*It’s the relationship—  
between the therapist and the music  
and the child and the music  
and the therapist and the child and the music. (ME)*

**Relationship-building with children.** ME remarked, “The real reason why many people choose music therapy for their child [is] because of the relating...how we can enhance the relationship.” Relationship remained prominent in the five interviewees’ descriptions of interacting with children. When the participants were directly queried about their process of relationship-building, the ensuing conversations produced 73 meaning units that collectively aligned with this theme. The elements each clinician cited as most important to relationship building are listed in Table 1. Cross comparison of the content then follows.

Table 1.

*Important Elements of Relationship-building as Cited by the Interview Participants*

ME	BR	AG	GL	CT
Valuing/Respect/ Individuality	Respect/Dignity	Respect/ Emotional support	Respect/Dignity	Respect/Caring/ Sensitivity/ Reciprocity
Communication/ Connection	Communication/ Connection	Communication/ Participation Connection/ Rapport	Communication/ Connection/ Honesty	Communication/ Nurturing interaction
Attunement	Attunement	Attunement/ Process vs. Product Orientation	Being Fully Present/Listening	Attention- Listening; Rapport/ Attunement
	Empowerment/ Validation	Self-esteem/ Independence/ Empowerment	Empowerment	Empowerment
Trust	Trust/Safety	Safety	Trust/Safety	Trust/ Authenticity
Powerful Moments		Therapeutic Moments		“Peak Experiences”
Fun	“Being Quite Silly”	Humor/Fun/Joy		Playfulness/ Enthusiasm
Acceptance	Validation	Valuing	Acceptance/ Valuing	Acceptance/Caring
Close Bonds			Boundaries	Bonding
		<u>INTERFERENCES</u>		
Challenges/ Disruptions/ Unrealistic Expectations	Disconnection/ Relational breakdown	Challenges/ Disconnections	Avoidance/Power inequity/Frustrat ion/Transference -Counter- transference	Defensiveness/ Frustrations/ Disconnection

*Comparing relationship-building elements.* Controlling for semantic variation by cross-referencing the supporting texts allowed the researcher to align the delineated relational components according to following general themes: acceptance, caring, and valuing; trust, safety, and authenticity; establishing boundaries; communication, connection, and interaction; attunement, listening, and being fully present; powerful moments; humor, playfulness, and fun; validation, independence, empowerment, and self-esteem; dignity, respect and sensitivity; challenges and disconnection. Rendering of these thematic spheres follows:

*Acceptance, caring, and valuing:* Several participants emphasized that a music therapist's ability to convey acceptance, caring, and valuing contributed significantly to creating alliances with children. BR noted that any manner of child response could form the basis for therapeutic intervention. ME stressed "that acceptance piece, you know, value the individual." CT stated that a therapist's "tone of voice, volume of voice, asking permission," were all features of acceptance and stressed that a tolerant stance was imperative when working with vulnerability. A quote from GL exemplified the concept of unconditionally valuing whatever a child was able to offer:

GL: Being accepting. And the ability to accept ugliness, the ability to accept rage, the ability to accept being pushed away; accepting whatever they give. They can come, bring whatever they need to of their baggage and find that they as a person are accepted...Not accepting the behavior, accepting the person.

*Trust, safety, and authenticity.* Fostering trust, creating a sense of safety, and being authentic with children comprised another important relational component identified by all interviewees. ME described her therapeutic alliances as based on "trust and positive energy," stressing that it was vital that young children felt safe and found her interactions nonthreatening. BR stated that consistent structure promoted comfort: "When kids come to my room, they trust [it's] going to be the same." CT remarked that being honest and authentic were imperative for gaining a child's acceptance: "Kids are pretty savvy, when you're not genuine."

GL explained that the overriding concern of students with emotional issues was "Can I trust you enough [to] tell you the truth?" He noted that establishing a secure environment for exploration and growth, promoting a sense of safety, and de-

emphasizing adult-child power inequities allowed students to develop their personal learning styles and strengths. For students to feel secure enough to respond, AG observed, “You can’t make *too* big a deal, or you’ll scare them, and it’ll never happen again” and that it was vital to “know where you really are with them and what they will do for you.” Lastly, CT clarified that trust supported relationship for both partners and explained that she needed to trust “the child to guide where they need to go” while simultaneously working to gain a child’s acceptance.

*Establishing boundaries.* The level of participant response indicated that maintaining appropriate therapeutic boundaries was another important component of creating relationships with children. This topic was especially prominent in GL’s commentary. He emphasized that productive therapeutic liaison depended not only upon connection but bounded structure as well: “I try and honor the relationship while setting boundaries. Boundaries are important; Boundaries are very important.” For him, limit setting took many forms: physical position (“The concept of personal space is *so* difficult”), adult-child dynamics (“Hugging; I just don’t do it. It can set up a relationship that doesn’t exist... in the mind of the student.”), constructive guidance (“Bring it back to where it needs to go”), or restricting personal involvement (e.g., refusing to engage with students on social media). GL stated that adhering to appropriate therapeutic boundaries allowed him to maintain “a sense of distance from the strength of their emotions.”

For some of the interviewees, gender played a role in maintaining appropriate therapeutic limits. The following comments exemplify two female participants’ acknowledgement that close bonds with children could stir strong sentiments:

ME: As a music therapist who works with toddlers, I think we fall in love

again....how maternalism comes in...for me that's intertwined. When you work with toddlers, you don't have the empty arm syndrome...And they run to you, they hug you...I love the light in those eyes. Those little eyes!

CT: There are certain kids that—just like with people—you connect with more than others for whatever reason...you can really build a very strong bond and a deep caring.

Likewise, GL cautioned that his gender could be problematic for children who “come from families where the male in the family is inappropriately the power figure” and stressed the need to be cognizant of potential transference issues. He also cited gender-related limits he adhered to:

GL: [I] always have to be cognizant of liability. I will not see a female student in a one-on-one situation in a room by myself. I also hesitate to see boys alone; As a male; I have to be aware of that.

*Communication, connection, and interaction.* Communication in many forms emerged as an integral component of relationship-building. BR cited children's intrinsic communicative abilities: “I have confidence in them as communicators. If they're having a behavior, what is that behavior communicating?” In fostering connection with students, AG explained that she also focused on nonverbal responses, “reading them and their body language” and responding to “whatever the ‘its’ are that they seem to need.” She noted that active participation, choice making, gestures, expressions, language, physical connection (e.g., touch; proximity), visual cues, and emotional bonding (“that sense of...it's us”) were all forms of communication.

GL stressed equality of voice for both relational partners (“I am very interested in:

What is your interpretation?") noting that authenticity necessitated that he be to be open and honest with students:

GL: I often have students who say, "Mr. [X], you have no idea how I feel; you've never been abused by your father." And I'll look at them and I say, "You know, you're right. But I've been very angry...and I don't know if the level of angry that I've been anyway reaches the level of angry that you feel, but I can honor your feelings of being angry because I've felt angry."

CT accentuated the need to exercise great care in how you communicate with children and to remember that non-verbal communication can be very powerful: "My nonverbal face... I'm very expressive, probably too much." In her opinion, it was always important to be "really careful in how we choose our words" when praising a child:

CT: It's not always, "Oh, I think you did a good job." I think we have to be careful how we give feedback to kids...phrasing it in a way that it comes from within the child: "You figured out how to make that drum work!"

The central role of musical communication and connection was also highlighted in several ways. ME spoke about "let[ting] a musical tone draw their attention" while GL underscored his preference for "doing it through the music." CT pointed out that the expressive potential of music created the opportunity for a unique, reciprocal connection with children.

*Attunement, listening, and being fully present.* The following passages illustrate how the participants struggled to verbalize their conceptions of attunement:

ME: Being engaged with...more than engaged. Being on the same page...in a relationship...in a working relationship...that is on common factors...Being in

sync...[and later] It's beyond the music; it's a communication.

CT: Connected...but on a level that's deeper than the superficial...In your soul!

It's that deep connection you have with somebody where you [Touching her heart]...Yeah. You know then how to use the music in that time. You know what you need to do.

AG accentuated process-level interaction as "the key piece" of attunement:

"When you are attuned to your group, you're functioning on a process level." BR depicted attunement both in musical and nonmusical terms. Behaviorally, she spoke about eye contact, physical presence, and observing "where the child is," while also highlighting attunement's emotional and musical aspects: "But attunement in the moment is definitely an affect; and it's also a musical...an aesthetic experience...an emotional response to the situation." She offered a "magical" example:

BR: The time was just passing; it was suspended and it was so positive because up till then he'd had so many aggressions. But for that half hour, we were connecting; we were playing together. He was looking at me; patting to the music...allowing me into his set.

Two participants expanded the concept further. GL spoke about being "fully present" noting that he relied on "in the moment" musical connection to gain therapeutic insight: "What are they telling me? Where do they need to go next?" He explained that "listening and hearing and then accepting whatever they give" allowed him to find the "message behind the message." CT explained that attunement involved "empathic listening" ("listening deeply" with ears, eyes, body), "undivided attention for the whole time," and being "fully there with them." She offered a portrayal of attuned responding:



CT: When something sort of changes in the session. And for some reason, intuitively you know just the right thing to do...that pops in your head...that maybe you haven't tried before. And it works...and you're like, "Whoa, where did that come from?"

*Powerful moments.* Working within musical relationship had afforded these clinicians some of the most meaningful and potent experiences of their careers as evidenced by the numerous stories they related during the interviews. ME spoke about seeing a young burn victim reach out his badly damaged hands for the first time to tap a balloon-filled parachute along with the music: "That was a pretty powerful moment!" AG's story of a student with autism illustrated how these compelling experiences were often facilitated by the music:

AG: I remember Jason...we were doing "Pass the Puppy" for sharing...and the parents were there. He handed the dog to mom and he kissed her...and she left the room [overcome with emotion] because he had never done that before!

CT described the performance of a rock band she formed with two teenage burn victims as one of the "peak" experiences of her career:

CT: [We performed] in our auditorium at the hospital; we had lights; we had patients and staff come and listen; we did about six songs. It was amazing! For all of us, that was a new experience. We all shared something very new together that will never be able to be replicated again! It was so unique—just really extraordinary. So I think without the music, that couldn't have happened.

*Humor, playfulness, and fun.* Several participants noted that infusing their work with humor and playfulness assisted children's progress. BR spoke of not being afraid to

“be quite silly” in order to engage children. AG stated that she used humor to circumvent those inevitable instances of student “push back” and explained, “I like to try and tease them, fool them” in a positive way. ME described how being “playful” often sparked “wonder and joy in these little guys...They were really excited to learn. They liked music. They thought it was fun; enjoyable.” CT noted that she continually sought “those funny moments” and opportunities for “bringing joy” to others—children and colleagues:

CT: Having that connection to...joke with them or if they’re like, “Oh, I’m just in the mood for a song,” I will stop in the hallway with the guitar and just have that little moment with the staff.

*Validation, independence, empowerment, and self-esteem.* Empowering and validating children’s independence and self-confidence surfaced as another salient element of relationship-building. BR spoke about fostering a child’s self-esteem by “giving him the authorship; that’s very validating.” AG underscored the need to “make sure that you’re empowering them” by allowing students to make choices, exercise creative freedom, and build confidence (“I can help them feel successful; help them feel capable.”) For children with emotional disabilities, GL explained that focusing on their responses, engaging them in the decision-making process, guiding rather than directing, and supporting independent choice empowered them to take ownership of their skills. In contrast, he noted that promoting independence for children with autism frequently involved building specific skills or teaching them to interpret social cues. This comment exemplified how self-esteem and empowerment were essential elements of building and integrating children’s skills into long-term, functional behavior patterns:

BR: If I don't give them the independence, if I don't give them the opportunities to make choices, and if I don't honor their preferences, then they're not going to be as successful in their adult [lives]... the independence and the confidence that is so important for them as adults in the community...whatever their situation.

*Dignity, respect and sensitivity.* Lastly, all five clinicians underscored the centrality of respect and sensitivity to the relational process. GL stated that productive relationship must be based on "dignity and respect." AG spoke about "catching" the smallest of responses, reading and respecting body language, and supporting children emotionally ("help people save face"). BR emphasized "dignity—I think that's a huge gift that we can give these kids; honoring their choices and giving them their respect and dignity." ME's remark illustrated that respecting involved recognizing individuality:

ME: We have to tailor-make how we deal with each person...but I think it goes even deeper, because it's a respect. I think you have to *respect* each child...

CT spoke the most extensively about respect and sensitivity, noting that without respect "they're not going to trust you; I think that builds from there." She explained that she strove to remain sensitive to and respectful of the circumstances that brought her in contact with children and react accordingly: "If it's a situation where they're in pain, you want to counterbalance that." For her, respect involved reciprocity: "They're watching my cues, noticing if I'm responding to them and respecting them:"

CT: The kind of things that are really part of respecting—the personal space and their emotional state and being cognizant of their physical abilities and ...not pushing and just really...in the moment knowing where they're at.

She captured the essence of the interviewees' ideas when stating that sensitivity and

respect—for family, culture, colleagues, and most importantly, for the children themselves—were the true foundations of relationship, noting that “you have to give it to receive it; you have to earn it.”

*Challenges and disconnection.* The participants provided a number of examples in response to questions about challenging issues that arose in their work with children. While generally viewing challenges positively, they also acknowledged that there were occasions when problems negatively impacted their work, themselves, or their relationships with children. BR emphasized the importance of guarding against disconnection resulting from her personal desires becoming “more important than their needs.” GL underscored how transference issues could negatively affect therapeutic relationship:

GL: I realize that they have projected their feelings of frustration onto me. Why am I feeling frustrated? Because they gave it to me so they don’t have to feel it anymore!

CT spoke about how she felt marginalized by comments such as “It must be so nice to play music all day” which stemmed from a lack of professional understanding about music therapy. A quote from ME illustrated how unreasonably high expectations, either her own or those of others, caused personal frustration:

ME: There’s a problem...if you do a decent job, people just want more and more from you. And you get the hardest cases...you know it’s a challenge. We learn from that.

Challenges related to the children were reported as the most disconcerting. ME spoke about the pain involved in losing a child (“It’s hard to see the parents suffer.”) GL

provided an example of when relational disconnection surfaced within a session:

GL: Sometimes...the kids are just NOT there! They are not present for whatever reason. And so you try and start off with the goal setting circle...you try and do something musically to see where the group wants to go and it doesn't come together. And you get to the end of the group to wrap up and you think, "We haven't gone anywhere!"

AG and GL described their strong reactions when encountering situations where they personalized issues or encountered therapeutic roadblocks:

AG: It feels horrible; because...you're pushing against a brick wall; you're not in sync. You get frustrated and your gut is in it; you're drawing a line in the sand...

GL: This is music therapy. This is supposed to work. And it's not working!

There's that frustration. Why is this NOT working?

When asked how they responded to challenges and disconnection, GL spoke about problem solving with his students by "putting it on the table." AG cited self-reflection:

AG: Something isn't right. I either have not planned the lesson well enough; I haven't excited them about it; I haven't prepped it enough...it's not going to sell...You've got to go back to the drawing board; you've got to figure it out.

ME expressed thankfulness that such disruptions had become "fewer and far between" as her career progressed. Avoiding such challenges and disconnection all goes back to "respect," BR commented—respect for the child and respect for the relationship.

*Final thoughts on relationship.* Ultimately, these five clinicians' comments demonstrated their belief that accepting children, valuing whatever they bring, communicating and connecting (musically, verbally, behaviorally), being honest and

authentic, creating safely bounded structures, empowering and supporting connection through attuned responding and being fully present, and above all, affording children dignity and respect comprised the requisite elements of engendering productive therapeutic alliance. As GL observed, these foundational building blocks were all “part of a respectful relationship” that supports successful music therapy intervention with children. CT offered a musical parallel:

CT: It can kind of have a musical analogy...when the music changes so suddenly, it's jarring...but when it...slowly builds...by the end, it's rich and full!

*The ability to listen! ...And I'm talking MORE than just listening with my ears.*

*Listening with my eyes; listening with ah body language,*

*Listening to the message behind the message...*

*REALLY being fully present when you listen. (GL)*

### **Essential Music Therapist Attributes**

The final question posed during each of the five interviews centered on exposing the personal attributes that these experienced clinicians felt were essential to establishing productive relationships with children. It was interesting to note how easily the participants were able to enumerate qualities they saw as indispensable. Analyzing this commentary in conjunction with supportive content drawn from throughout the interviews enabled the researcher to categorize the delineated attributes into four content domains: personal qualities, relational abilities, cognitive abilities and the music.

**Personal qualities:** The interviewees outlined the personal qualities they felt assisted them in connecting with children, staff, and families. The 53 total attributes listed in Table 2 demonstrate the significance these clinicians placed on their personal abilities.

Table 2:

*Personal Qualities Delineated by Interview Participants*

ME	BR	AG	GL	CT
<u>Personal Qualities</u>	<u>Personal Qualities</u>	<u>Personal Qualities</u>	<u>Personal Qualities</u>	<u>Personal Qualities</u>
	Sincere/Genuine/ Honest	Genuine/Giving nature/ Need to help others- make a difference	Honesty/ Appropriate Self- Disclosure	Genuine/Honest/ Authentic
Flexible	Flexible	Flexibility	Flexible	Flexible
Open-minded	Open-minded/ Fresh perspective		Open-minded	Open-minded
Accepting/ Nonjudgmental	Non-judgmental Attitude	Non-judgmental/ Empathetic/ Embrace multiple perspectives — child's & own	Accepting/Non- judgmental/ “There” for children	Non-judgmental/ Avoid expectations- Preconceptions
Patient/ Empathetic	Patient	Patient		Patient
Self-assurance/ Professional Confidence	Good Self-Esteem	Confident/In control/ Commanding Presence	Confidence in One's Abilities	Self-confident/Self- reliant/Self-aware
Passion-For Children/ For Music Therapy	Personal Passion for the Work/for Children	Passion for the Work and the Students	Passion-for work & children Open- minded	Love for children/ Passion for Music Therapy Profession
Positive/Present/ Excited in Moment/ Spontaneous		Inquisitive About Students- Challenges	Truly Engaged/ Enthusiastic Inquisitive Stance	Spontaneous/ Explorative
Put Aside Personal Agendas/ High Personal Standards	Self-awareness/ Honest with self/ Deal you're your personal issues	Strong self-awareness	Keen Self- Awareness /Clear Sense of Self-Ego Strength	High Standards- Musical & Ethical
Safe-Not Feel Threatened	Good Boundaries- separate person from Therapist/ Not personalize issues	Defined Personal Boundaries- Separate person from therapist	Strong Personal Boundaries- Separate self from therapist role	Clear Personal Boundaries/ Aware of Safety Concerns
Positive Outlook- Be a Happy Person		Predictable/ Approachable	Professional Satisfaction	Reliable/Consistent- Following Through

**Relational abilities.** ME described her ability to effect positive change as based squarely on the relationships she formed with young children. GL explained that he sought to connect with students at the emotional level necessary to create trusting alliance. BR, AG, and CT all cited the correlation between creating positive working

relationships and their effectiveness. The participants delineated a total of 58 essential relational abilities as presented in Table 3.

Table 3.

*Relational Abilities Delineated by Interview Participants*

<b>ME</b>	<b>BR</b>	<b>AG</b>	<b>GL</b>	<b>CT</b>
<u>Relational Abilities</u>	<u>Relational Abilities</u>	<u>Relational Abilities</u>	<u>Relational Abilities</u>	<u>Relational Abilities</u>
Value/respect child- family-culture	Respect/Value/ Accept the Child- Provide Growth- Fostering Dignity for Children	Respect Children: Needs-Boundaries Value-Accept children's responses and creativity	Respect for Students & Process; Accept/ Value/Embrace what children can give as a starting point	Promote Respect/ Value Child-Family/ Caring Posture/ Accept what child offers unconditionally
Establish Trust/ Safe atmosphere	Engender Trust/ Safety	Engender Trust/ Safe atmosphere	Create Trusting Bond	Engender Trust/ safe-secure-stable atmosphere
Child-centered	Child-centered; Sensitive to needs- desires/ Honor child's Choices- Reserve judgment on ideas-actions	Child-centered/ Child's needs take precedence Believe in-Expect Children's Success	Student-centered: Emphasis on their ideas/"their journey"	Child-centered: Allow child to explore at own pace/ Engage Family & Culture/ Environment
	Empower children/Foster independence	Empower Children's Independence- Ownership of skills	Empower Students to take Ownership of Strengths/ weaknesses	Empower child/give "locus of control"/ Foster resilience Lessen dependency-fear
Nonverbal: Eye contact, Facial expression, Be at child's level/"Up close and personal"		Create rapport/Be Attuned/ Ability to Read Children- Situations	Be connected/fully present/ in the moment	Rapport: Attuned, In the moment/fully present/ Supportive presence: voice, volume, nonverbal expression
Casual/Quiet/ Non-threatening relational style	Non-threatening- Level-Steady/ Match demeanor to situation-Not overwhelm child	Supportive Physical Presence/ Physical Contact as Appropriate	Emotionally engaged/ Remain engaged through discomfort	Patient-gentle-calm approach/
Avoid "Too many words"			Maintain Open Lines of Communication	Astute Listening/ Sustained Attention
	Employ humor; Be "a little silly"	Employ Humor- Have Fun		Use humor-Fun- Joyfulness
Enthusiastic/ Playful Demeanor	Dynamic approach with groups	Engaging-animated, Interactive Approach		Playful-enthusiastic- positive-sharing- animated demeanor
Non-territorial/ Global-Team approach/share techniques -info	Promote Relational Equality between Therapist & Child		Downplay Teacher- Student Inequity	Downplay power-size inequities/ Be physically "at their level"
Patience/Ability to wait out responses			Guide rather than Lead/Offer alternative strategies	Guide rather than direct



**Cognitive abilities.** Cognitively, ME and AG cited behavioral training as highly beneficial in their work with children. GL and CT noted that they relied heavily on theoretical knowledge. BR's promoted "a willingness and a passion to learn...because every year, I feel like I'm starting a new job; there's new kids, with new issues, with new ways of being." The 40 delineated cognitive abilities are presented in Table 4.

Table 4.

*Cognitive Abilities Delineated by Interview Participants*

ME	BR	AG	GL	CT
<u>Cognitive Abilities</u>	<u>Cognitive Abilities</u>	<u>Cognitive Abilities</u>	<u>Cognitive Abilities</u>	<u>Cognitive Abilities</u>
Highly flexible cognitive stance/ Many ideas-Alter direction repeatedly	A Flexible Stance	Flexible, Creative Thinking	Robust Flexibility and Creativity	Flexible Cognitive Stance and Creative Outlook
Task Analysis Skills	Strong task analysis Identify-build on small steps of progress	Task Analysis Skills Strong Assessment Discern-layer-integrate skills	Assessment Ability- Analyze responses - strategize intervention /ongoing questioning	Ability to assess in the moment
Strong Observational Skills	Observation/ Ability to Assess Behavior	Adept Observational Skills	Keen Observation Abilities	Observation-Assessment skills/
	Strong Listening Abilities	Keen Listening Abilities	Acute Listening Abilities	Strong Listening Abilities
Adept Communication abilities			Well-honed Communication Skills	Communicate clearly/Convey one's reasoning
Need to remain open to learning	Remaining open to Learning	Continual Learning	Continual learning/	Continual Learner-Open to new ideas
			Open to supervision/ Willing to draw on others' insight	Accept feedback-insights from others
Ability to Structure Positive Working Environment	Aptitude for environmental structuring	Ability to design therapeutic environments-structures for work		Structuring Ability-Design appropriate environment for the work
			Strong theoretic base: Evaluate-interpret observations through methodology	Draw eclectically from strong theoretic foundations
	Ability to Individualize the Therapeutic Process		Ability to draw on experience and therapeutic "tools	Strength Perspective-work from child strengths in designing treatment

**The Music.** AG stated that she viewed working within the music medium as a privilege. CT observed that music-based interventions allowed her to approach children in a very different manner from other professionals. Table 5 presents the 35 musical qualities that interviewees cited as essential to harnessing music’s therapeutic power.

Table 5.

*Music Qualities as Delineated by Interview Participants*

ME	BR	AG	GL	CT
<u>Music Qualities</u>	<u>Music Qualities</u>	<u>Music Qualities</u>	<u>Music Qualities</u>	<u>Music Qualities</u>
Music’s ability to promote-wonder-joy	“Confidence in music” to guide interventions	Music as a participatory medium for therapy	View of music as a “co-therapist”	Music as a “secret weapon”
A passion to share music/ Love for music shines through	A personal “joy in music;” deep connection with music	Personal appeal of music-Boosts passion for work	Personal passion/ Enduring commitment to music	Personal connection/Ongoing passion for music
	Access music in the service of others	A powerful therapeutic tool/strength as a nonverbal intervention	Unique-persuasive-enticing tool with students	View of music as a unique, “powerful tool”
	Flexible improvisational framework		Flexibility of improvisational music framework	Flexibility/ musical improvisation’s reciprocity
Music as learning vehicle not performance		Music as a “process not a product”	Music’s ability to act as a “container” for the work	Adaptable nature of music-instruments-ensemble/
Music’s ability to create a connective bond		Ability to set a positive social environment/ Inherent group nature of music		Preference for “live” music’s immediacy (quality recorded music when needed) connection-fostering social qualities
Musician + Therapist stance				Musician + Therapist stance
Discerning ear for highest quality music			Solid musicianship Provide best music-music experiences	Have broad musical knowledge/ Produce quality, authentic music/ Excellent musicianship/

**Counter-productive traits.** CT and AG also offered a number of attributes they felt were counter-indicated in fostering therapeutic relationships with children. CT noted: (a) people who like to punish or find fault, (b) people who want to have control over a child, (c) people who don't allow a child to explore, (d) people who can't tolerate children's crying, (e) people who label all the time, and (f) those who were "too formal; somebody who had never enjoyed playing." She stressed that "you could damage the child if you have that kind of approach and attitude."

CT: When you hear a negative statement to a child made, it takes 10 positives to undo it! It's so critical at the stage that they are in; It sets them up to be who they are!

AG cited: (a) people who "pour the music therapy over a person," (b) "not really giving a choice...not really waiting," (c) not being "engaged" with a child, (d) being rigid or non-observant, and (e) no passion.

In the end, CT commented, "There are certain people who can really hinder the ability for this child to grow...in a healthy way." Her final statement exemplified the central focus of these five children's music therapists: "To help them grow!"

### **A Comparative Analysis**

A cross comparison was conducted to discern whether commonality was present in the five interviewees' delineations of essential music therapist attributes. Tables 2-5 present a comparative inventory of the five participants' responses in each of the four essential attributes content domains: personal qualities, relational aspects, cognitive abilities and emphasis on music.

**Personal qualities.** The personal qualities a music therapist should possess

figured prominently in the interviewees' responses with a total of 53 attributes listed in this area. Analysis showed that nearly all the entries demonstrated cross threads across two or more participants. When the various terms were aligned with more general categories, five of the cited qualities—flexibility; self-awareness/self-knowledge; self-assurance/confidence/self-esteem (ego strength); passion/love for the work and for children; being nonjudgmental (accepting/empathetic/ approachable)—demonstrated full consensus among all five participants.

Four more qualities were cited by four of five clinicians: maintaining healthy boundaries (separate therapist from self/not personalize), open-mindedness, patience, and sincerity (honesty/genuineness/authenticity). An inquisitive-explorative stance and being spontaneous (excited in moment/enthusiastic) were highlighted by three interviewees. Two participants cited dealing with one's personal issues/agendas, personal security (not feeling threatened), being consistent -predictable-reliable, and maintaining high self-standards. Only three out of the 53 listed personal attributes were limited to only one response: a happy-positive outlook, a giving nature, and finding professional satisfaction. These three qualities, however, had found support within most respondents' discussions.

It is important to note that in a number of cases, different terms were employed to evoke a similar concept (e.g., accepting vs. nonjudgmental; self-knowledge vs. self-awareness). Such semantic disparities were especially salient in the respondents' descriptions about being "self-assured" (e.g., confident vs. ego strength vs. in command vs. self-reliant.) In several instances, an inclusive label broadly described a concept that others had more exactly portrayed. For example, GL's explanation of "ego strength" indicated that, for him, this term encompassed self-awareness, confidence, and feeling

non-threatened. At other times, different terms depicted the same concept. Such was the case with AG's descriptions of "accepting" and "empathetic" which proved strikingly similar to what the ME and GL termed "open-minded." When controlled for these semantic variances, substantial overall agreement emerged about the personal qualities these clinicians found essential in a children's music therapist.

**Relational abilities.** This domain demonstrated the highest density of all categories with 58 traits collectively cited. Once again, considerable accord was witnessed across the interviewees' responses. The concept of "respect" drew the strongest consensus. All five clinicians stressed the central role of one or more aspects of respecting and valuing—the child; the child's choices, responses, family, cultural background—when engendering productive therapeutic association.

Similarly, all participants cited the importance of being child-centered in their approach. They commented repeatedly that a child's needs should always take precedence in the therapy relationship (e.g., GL: "their journey") and spoke of productive association as based on rapport and connective bond. ME and CT specifically expanded these connections to include colleagues and family, though all five clinicians had cited the importance of collaborative relationships earlier in their respective interviews.

Demeanor and personal deportment figured prominently as well, though style disparities were witnessed in this area. ME, AG, and CT emphasized a playful, enthusiastic, animated, engaging, dynamic approach while ME, BR and CT accentuated being positive, casual, quiet, level and calm. Interestingly, ME and CT cited both relational styles. Three clinicians (BR, AG, CT) noted the effectiveness of humor. GL did not specifically offer his relational style, only speaking about preferring a guiding role.

The remaining relational attributes attained majority agreement among the respondents. Four participants underscored the importance of being fully present and attuned in their relationships with children, offering identifiers such as rapport, full attention, being “in the moment,” supportive physical presence, reacting spontaneously, or “reading children’s needs.” GL also spoke of maintaining therapeutic connection even in the presence of intense or discomforting emotion. ME and CT specifically described the physical attributes of attuned responding (e.g., eye contact, proximity, facial expression.) Additionally, four of five clinicians directly cited unconditional acceptance of whatever children brought to the therapy process.

Empowering children, though garnering general agreement, was portrayed with a wide range of descriptors: giving children “ownership” or “locus of control,” fostering independence, providing opportunities for exploration, and ensuring children’s dignity in the relationship. Two clinicians (CT, GL) described their roles as “guides” versus “leaders/directors” while three (BR, CT, GL) spoke about promoting relational equity. Engendering safety, trust, and stability proved to be prominent relational qualities as well, being mentioned in some form by all contributors. BR emphasized open lines of communication while AG stressed believing in the child’s ability to succeed. Here again, clarification of semantic variance required contextual reference.

**Cognitive abilities.** The 40 total attributes delineated in this category also evinced considerable agreement. All five clinicians highlighted the importance of strong observational skills, stressing that their ability to discern “small bits of progress,” accurately assess behavior, identify child strengths, create effective structures, build integrated skills, and support children’s progress were all incumbent upon observational

expertise. Flexibility and creativity were noted as important relational qualities by all five participants. BR exemplified this flexible-creative cognitive stance when stating: “Come in with [plan] A, B, C, and then have D, E, F and if that doesn’t work, make sure there’s a G.” Maintaining a learner’s stance attained full consensus as well. Remaining “the learner in the situation” (BR), never making assumptions (CT), and not taking anything for granted (AG) were a few of the ideas offered in support of ongoing learning. Accepting professional feedback and drawing insights from supervision experiences were cited by GL and CT.

Four contributors noted the importance of being a “good listener” and the ability to structure appropriate environments. Three participants (ME, BR, AG) specifically delineated task analysis abilities as essential to effective planning and assessment while the remaining two clinicians (GL, CT) spoke of evaluation and interpretation through continual questions and analysis. Strong communication skills, drawing on theoretic foundations, and individualizing interventions were only specified by two participants. GL alone listed knowledge of therapeutic “tools” as essential. However, these were also cognitive attributes that all contributors had previously endorsed.

**The music.** All five participants focused in some manner on music’s importance—35 total entries were offered in this area. In various forms, each contributor cited a personal passion for music, an ongoing, deep connection with music, and their need to share their love of music as central to their identities as music therapists. Notably, they highlighted using their music in service of others rather than focusing on musical performance. Specific descriptors included: “process versus product” orientation (AG), music as a “co-therapist” or “container/vessel” for the work (GL), music as a “secret

weapon” (CT), “music as service” (ME), “confidence in music” (BR), and music as a powerful, unique, persuasive, adaptable tool.

Resonant with all interview discussions, three respondents (ME, GL, CT) specifically cited the importance of providing children with quality music and musical experiences. Strong musicianship was emphasized by GL and CT while BR, GL, and CT emphasized reliance on an improvisational music framework. Only CT advocated for broad knowledge of musical genres and specifically noted a strong preference for live versus recorded music.

“Musical connection” was highlighted as a foundation of therapeutic progress with participants underscoring music’s power as a change agent (e.g., GL: a communicative avenue when “words were inadequate.”) AG and CT pointed to the “shared” nature of music as efficacious in promoting interpersonal skill development. ME spoke about creating musical bonds that fostered joy and wonder in young children. BR described the relationship between music therapist and child as being “shaped by the elements of music.” AG cited music’s nonverbal, group orientation as optimal for promoting a positive social environment for children.

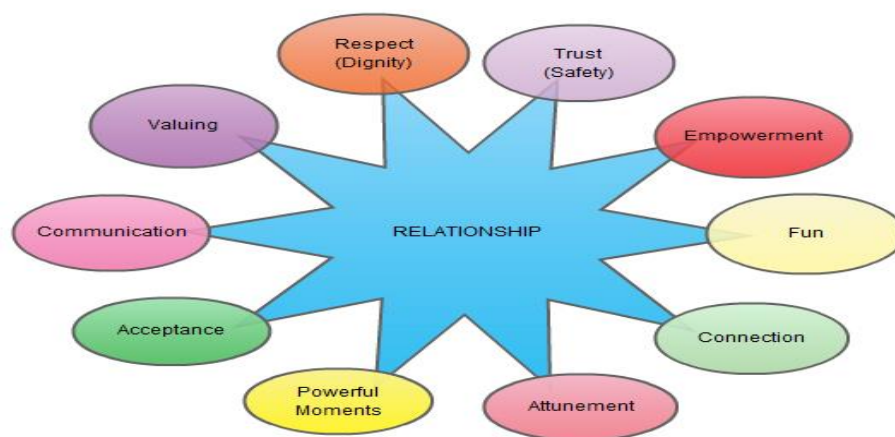
The prominence with which the music itself surfaced as one of the essential attributes domains was notable. Though expressed in a variety of ways, each contributor viewed music as central to their therapeutic effectiveness. CT and ME expressly depicted this orientation as a “musician + therapist” stance.

**Examining relationship.** Since relationship was so strongly emphasized by the interviewees, a comparison of the participants’ descriptions of this concept is warranted. In examining the contributor responses about relationship, the consistency of descriptors



proved most compelling. In some form, all five clinicians highlighted respect-dignity, attunement, communication, connection, and trust-safety as central components of therapeutic alliance. Valuing, acceptance, empowerment, fun-humor-joy, and powerful moments received strong support as well. Figure 1 depicts the interrelated components of relationship as delineated by the five participant music therapists.

Figure 1. Components of relationship



*Figure 1.* The components of relationship as delineated by the five participant music therapists. The ten identified facets all connect with and sustain the relationship core.

**General observations.** A final review of the interviewees’ individual chronicles exposed a number of overarching emphasis points within their discussions. These seminal ideas have been included here as a means of drawing closure to the discussion of a music therapist’s ability to engender productive therapeutic alliance with children.

ME spoke about remaining sensitive to the rapid development of young children and stressed the need to focus on the “whole child” and to think “long term” in working to develop a child’s abilities. BR cited music-based alliance and a consistent focus on children’s needs as the true foundations of her work. AG highlighted the individualistic and highly relational nature of music therapy intervention, stating that her emphasis on

helping students find their own strengths translated into a long-term, forward-looking vision and the ability to “see where it needs to go.” GL described the therapeutic relationship as a give and take process and believed that his effectiveness as a children’s music therapist stemmed from creating respectful relationship: “the relationship is so critical—you damage the relationship, you’re done!” In his opinion, a child’s need to acquire life-long social competence could not be overemphasized. CT attributed her success to the unique avenue for connection provided by music-based relationship and accentuated her central focus as a music therapist—children’s recovery and growth.

Delving deeply into these clinicians lived experience evinced that all five participants operated from an inquisitive stance and viewed their work with children as a positive challenge. They repeatedly described situations that portrayed an orientation toward the other in their thinking. Not only did this stance require them to adopt a positive countenance and structure productive learning environments, it also required meeting children’s needs within an affirming alliance. Ultimately, their success as children’s music therapists centered on what AG depicted as the ability to “see the positives” in establishing respectful relationship, or as CT stated, “Respecting. Yeah. It’s huge... in every relationship!”

*Seeing what this child is ABLE to do... This is why I think music therapy is SO beautiful!*

*Because we always look at what they CAN do and NEVER what they can’t do...*

*We assess from that sort of strength perspective...And I LOVE that! (CT 2012)*

## **Phase Two Results**

The Phase Two survey sought to gather information from music therapy educators and clinical trainers about the status of fostering essential personal attributes and

relational abilities in music therapy students. A total of 37 objective and open-ended questions which were divided into three sections: Essential Music Therapist Attributes, Training of Music Therapist Personal Attributes, and The Music Therapy Education or Clinical Training Process. Results were compiled using a combination of quantitative and qualitative analysis as applicable to specific question formats. Demographic information was also solicited to further demarcate survey participants as well as afford comparison with the AMTA membership as a whole.

### **Survey Response Level**

The original AMTA member contact list contained 291 potential participants with 119 identified as music therapy educators and 172 as national roster internship clinical trainers. When controlled for redundancy, inactive email addresses, and opt out selection, the active respondent pool stood at 261. Ultimately, 118 participants completed the full survey with 14 partial responses recorded producing a 50.2% initial response rate. In assaying the partial responders, eight completed most or all of Section I while one answered all but the final survey question. The remaining five partial completions warranted removal, however, since no actual data beyond demographics was provided. Thus, the adjusted participation rate for the Phase Two survey stood at 127 or 48.27% with individual question responses ranging from 118-127. By comparison, Thomas (2004) reported that a meta-analysis of 49 studies containing 68 surveys conducted by Cook, Heath, and Thompson (2000) found the average response rate to electronic surveys to be 39.6% (p. 124).

### **Demographic Information**

In order to obtain a more exacting portrayal of the survey participants, the

following demographic information was collected: music therapy credential or designation, length of professional career, education level, age, gender, and primary ethnicity. Of the 127 contributors, 123 (97.6%) self-identified as carrying the recognized music therapist-board certified credential (MT-BC) from the Certification Board for Music Therapy (CBMT, 2014) while the remaining four respondents self-designated as holding either the registered (RMT) or certified/advanced certified (CMT/AMCT) music therapy designation (2 per category; 1.15% each). This finding met expectation since the participant pool was drawn from the AMTA membership list. AMTA guidelines for approved education and national roster clinical internship programs currently require music therapy educators and clinical trainers to carry the MT-BC (AMTA, 2010b).

Table 6. *Survey Participants' Professional Capacity and Years of Service*

	Less than 5	6-10	11-15	16-20	21-25	26 or More	Responses
Clinician	<b>5.6%</b> 7	<b>19.1%</b> 24	<b>20.6%</b> 26	<b>15.8%</b> 20	<b>9.5%</b> 12	<b>29.4%</b> 37	<b>126</b>
Educator	<b>16.4%</b> 11	<b>20.9%</b> 14	<b>23.9%</b> 16	<b>8.95%</b> 6	<b>8.95%</b> 6	<b>20.9%</b> 14	<b>67</b>
Clinical Trainer	<b>26.8%</b> 26	<b>21.6%</b> 21	<b>19.6%</b> 19	<b>12.4%</b> 12	<b>11.4%</b> 11	<b>8.2%</b> 8	<b>97</b>

Professional experience was broken out into three categories: clinician, educator, and clinical trainer as indicated in Table 6. All 126 question respondents identified themselves as clinicians with the largest group (29.4%) possessing more than 25 years of experience. Of the 67 respondents who further identified as educators, the largest groupings occurred in the 11-15 years (23.9%) or greater than 26 years (20.9%) categories. Overall, 75.4% of the educator respondents possessed more than ten years of experience. Conversely, 68.04% of the 97 self-identified clinical trainers cited 15 or fewer years of experience and 48.5% possessed less than 10 years. Lengthier experience

amongst educators again aligned with expected trends since AMTA guidelines presently require a minimum of three years clinical experience plus an advanced degree as a precursor to college teaching eligibility versus two years of experience and no advanced degree for clinical trainers (AMTA, 2010b). Notably, there were 38 respondents who self-designated as both educators and clinical trainers.

Education level was fairly evenly distributed across the participant sample, though somewhat skewed toward more advanced degrees (See Figure 2). Thirty-two respondents (25.2%) possessed a bachelor's degree, 52 (40.9%) a master's degree and 43 (33.9%) indicated having obtained doctoral degrees. Participant age was distributed across all categories as also shown in Figure 2. Average reported age was 43 years ( $R = 21-61+$ ;  $SD 11.4$ ). Highest age concentrations fell in the 41-50 years (28.3%) and 51-60 years (27.6%) categories with 69.3% being age 41 or above. Again, this appears to correlate with the experience requirements for eligibility to educate or train music therapy students (AMTA, 2010b).

Figure 2. Survey Participants' Education Level and Age

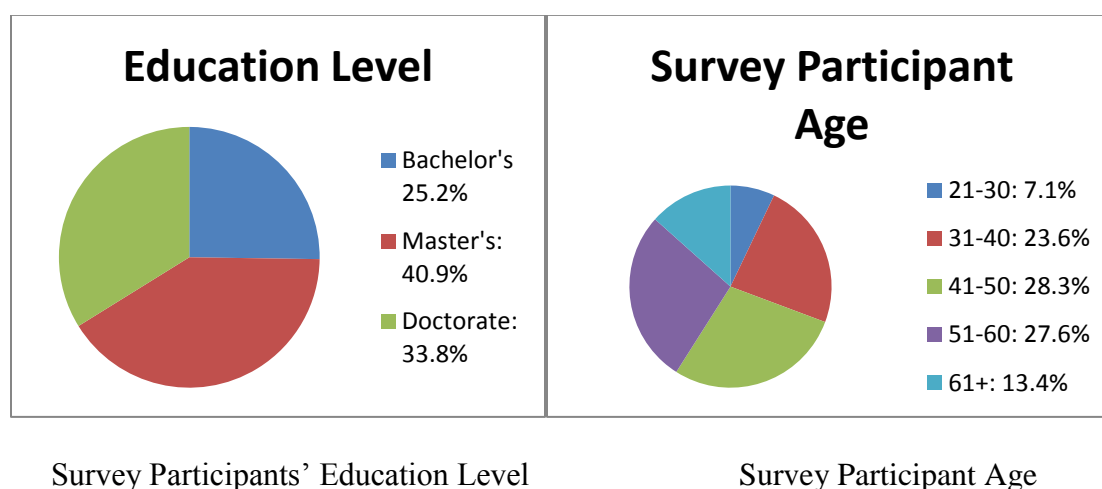


Figure 2. Demographic information about survey participants' education and age levels.

In terms of gender, 16 males (12.6%) and 111 females (87.4%) participated in the survey. This breakdown closely mirrored the 11% male demographic within the AMTA membership as a whole (AMTA, 2012). Moreover, 119 (93.7%) of respondents self-reported as Caucasian, while the remaining 6.3% described themselves as Asian/Pacific Islander, Black/African American or Other/Multi-racial. Caucasian ethnicity percentage of survey participants proved somewhat higher than the 87.9% level reported in the general AMTA membership (AMTA, 2012).

The participant sample was divided into two groups for Section III: music therapy educators and music therapy clinical trainers. The 49 respondents (41.2 % of the participant pool) who self-identified primarily as educators completed a set of questions pertaining to the music therapy education process. The remaining 68 respondents (57.1%) who self-identified as either clinical training directors or supervisors were directed to a set of questions probing the clinical training process. Two respondents (1.7%) who self-identified as not currently working in either category were automatically eliminated from further participation in the survey.

### **Section I: Essential Music Therapist Attributes**

Four categories of essential music therapist attributes were surveyed: Personal Qualities (16 attributes), Relational Qualities (15 attributes), Cognitive Abilities (12 attributes), and Musical Attributes (11 attributes). These domains and listed attribute sub-entries were drawn directly from the Phase One essential attributes delineated by the five interview participants. Survey respondents were required to rate the degree of importance they ascribed to each listed attribute using a five-point Likert rating scale (Very-Somewhat-Neither-Little-Not Important.) In addition, an open response box (Other)

allowed contributors to add any additional attributes they considered important within each category. The complete sub-entries charts and response levels for each of the four essential attributes categories can be found in Appendix F.

Upon completing each attributes category, participants were asked to rank order the top five attributes from within the category that they deemed most important for a music therapist to possess. These rankings were then tabulated to determine the five attributes with the highest overall selection rates.

**Personal qualities:** Results indicated high levels of agreement amongst respondents as to the importance of possessing the delineated personal qualities. Thirteen out of the 16 listed personal qualities (81.25%;  $r = 63.6\text{-}100\%$ ) were deemed either very important or somewhat important attributes for a music therapist to possess. Five qualities received 100% agreement as being very important: flexible; open-minded/spontaneous; nonjudgmental/accepting/empathetic; honest/authentic/genuine/sincere; good personal boundaries. Eight additional attributes received  $>90\%$  agreement when the two positive ratings (very important & somewhat important) were combined: strong self-awareness/personal insight (99.2%); stable/ reliable/ self-reliant (99.2%); self-confident/ positive self-esteem (98.4%); passionate about music therapy (96.8%); nonthreatening (96.1%); patient (96.0%); passionate about clients (96.0%); and enthusiastic/ engaging/ animated (90.6%). Only three entries—structured/predictable (80.0%); happy/ playful/ fun loving/humorous (78.5%), and display commanding presence (64.6%)—received less than 90% importance agreement from survey respondents.

The open-ended responses were qualitatively analyzed to ascertain salient themes. Not unexpectedly, this first response area yielded the highest number (26) of additional

entries in the “Other” category. Analysis determined that six responses were items already contained in the Relational Qualities category, twelve belonged in the Cognitive Abilities section, and three aligned with already delineated Personal Qualities. The remaining five entries cited being ethical, being intelligent, making good decisions, collaborating, and desiring to help/heal.

The five Personal Qualities respondents felt most important for a music therapist to possess were as follows:

1. Nonjudgmental/Accepting/Empathetic (91 of 127 responses; 71.69%)
2. Honest/Authentic/Genuine/Sincere (77 of 125 responses; 61.6%)
3. Flexible (65 of 127 responses; 51.2%)
4. Strong Self Awareness/Personal Insight (64 of 127 responses; 50.4%)
5. Possess Good Personal Boundaries (61 of 126 responses; 48.4%)

It should be noted that two answers proved indecipherable and were discarded from the rank ordering process; one simply stated “all of the above” and a second listed seemingly random letter (e.g., a, f, m) responses.

**Relational qualities:** Importance agreement was even higher in the relational qualities category. Fourteen out of the 15 listed qualities garnered >90% agreement ( $R = 91.9-100\%$ ) when the positive categories of very important and somewhat important were combined. Three qualities—have respect for client’s culture; caring/accepting/value client; engender trust—received unanimous rating (100%) as very important. Six more—respect for client; respect for therapy process; client-centered; connected/attuned/fully present; empower client; create safe environment—each garnered 99.2% combined positive agreement. Focus on positives/ability to succeed (98.4%), respect for client’s



family/family values (98.3%), foster client independence (97.5%), be emotionally engaged (94.3%), and assume a guide versus leader role (91.9%) also received very high agreement ratings. Only one sub-trait, appropriate self-disclosure, rated somewhat lower at 85.3%. Overall results indicated near universal agreement with all cited relational qualities.

Four open ended responses were recorded in this section. One comment aligned with Cognitive Abilities (“Be a good listener”), one was a global Musical Attributes comment (“Respect client’s prior relationship with music”), and the final two spoke generally of showing “mindfulness” and “being courageous.”

The five Relational Qualities cited by survey respondents were as follows:

1. Have respect for clients (103 of 122 responses; 84.4%)
2. Be connected/attuned/fully present (69 of 122 responses; 56.6%)
3. Be client centered (58 of 122 responses; 47.5%-a tie)
3. Create a safe environment (58 of 123 responses; 47.2%-a tie)
5. Be caring/accepting/value client (56 of 122 responses; 45.9%)

**Cognitive abilities:** Highest concurrence among survey participants was witnessed in the Cognitive Abilities area. Overall agreement level stood at 99.46% ( $R = 96.7-100\%$ ) across the 12 sub-entries when combining the categories of very important and somewhat important. Seven listed attributes—observational abilities; evaluation/assessment/interpretation; creativity; remain a learner; good communication skills; good listening abilities; able to individualize—garnered 100% combined positive agreement (very-somewhat important). Four more listed attributes—flexible thinking; possess theoretical knowledge; accept supervision; structure effective environment—stood at

99.2% combined agreement. Even the remaining response—able to task analyze—garnered 96.7% agreement across the two positive categories. Moreover, negative ratings (little importance-not important) remained at zero level across all listed cognitive abilities. In fact, only minimal neutral ratings (0.8-3.3%) appeared in this area.

Five “Other” entries were offered: “Assess own pluses & minuses” (Personal Quality); “quick thinking” (2 items); “intelligent;” “understand organizational dynamics.”

The top five Cognitive Attributes cited by survey respondents were as follows:

1. Strong observational abilities (81 of 121 responses; 66.9%)
2. Good communication skills (69 of 121 responses; 57.0%)
3. Good listening abilities (64 of 121 responses; 52.9%)
4. Strong evaluation/assessment/interpretation skills (62 of 121 responses; 51.2%)
5. Flexible thinking (54 of 121 responses; 44.6%)

**Musical abilities:** Though also receiving generally strong overall agreement (94.05%), Musical Abilities demonstrated the greatest range of scores ( $r = 82.8-100\%$ ) as well as some level of neutral or negative response to nine of the 11 enumerated attributes. Only two traits—able to individualize music/view music as a powerful tool—produced 100% agreement of highest level importance. Combined positive ratings (high-somewhat important) produced >90% agreement for seven more sub-listings—possess strong musicianship (99.2%); music as non-verbal communication (97.4%); music making as a process not product (97.4%), personal connection/passion/love for music (94.9%); utilize high quality music (93.9%); understand social nature of music (93.1%); strong improvisational skills (91.5%). However, emphasize live over recorded music (84.5%)

and music as co-therapist/musician + therapist stance (82.8%) both attained notably lower agreement of importance.

Of the seven “Other” comments, six pertained to musicianship--strong vocal skills/know many genres/versatile musician/be curious of role of music in client’s life—or relationship with music (“lifelong music learner/be musically interactive”). The final comment stated: “choosing live vs. recorded music is situation specific; not to rule out recorded music.”

The top five Musical Attributes selected by survey respondents were as follows:

1. Strong musicianship (92 of 118 responses; 77.96%)
2. Individualize music (84 of 117 responses; 71.8%)
3. Emphasize music-making as process not product (76 of 116 responses; 65.5%)
4. View music as a powerful tool (70 of 118 responses; 59.3%)
5. Understand music as non-verbal communication mode (56 of 117 responses; 47.9%)

Interestingly, the two top ranked musical attributes (strong musicianship; individualize music) attained nearly the highest level of importance agreement of all attributes in all domains, only surpassed by the Relational Quality: “have respect for clients.”

**Overall essential attributes.** Table 7 presents a composite rank ordering of the top 20 selected attributes from across all four domains. The qualities most frequently chosen by survey participants ranged from 103 citations (84.4%) for the top ranked attribute—respect for clients—to 54 (44.6%) for the twentieth quality—flexible thinking. Interestingly, the top 20 attributes proved evenly divided among the four domains (five

each), signifying parity among the four components of relationship building. Moreover, the data revealed that four of the top 10 choices were musical attributes (vs. 2 from each other domain), lending support to the significance that survey participants and interviewees all ascribed to the musical component.

Table 7.

*Overall Composite Rank Ordering of Essential Music Therapist Attributes*

<b>Rank Order</b>	<b>Essential Attribute</b>	<b>Category/ Ranking</b>	<b>Responses/ Total</b>	<b>Response %</b>
<b>1</b>	Have Respect for clients	Relational/#1	103 of 122	84.4%
<b>2</b>	Strong Musicianship	Musical/#1	92 of 118	77.96%
<b>3</b>	Individualize Music	Musical/#2	84 of 117	71.8%
<b>4</b>	Nonjudgmental-Accepting-Empathetic	Personal/#1	91 of 127	71.7%
<b>5</b>	Strong Observational Abilities	Cognitive/#1	81 of 121	66.9%
<b>6</b>	Music-Making as Process vs. Product	Musical/#3	76 of 116	65.5%
<b>7</b>	Honest-Authentic-Genuine-Sincere	Personal/#2	77 of 125	61.6%
<b>8</b>	View Music as a Powerful Tool	Musical/#4	70 of 118	59.3%
<b>9</b>	Good Communication Skills	Cognitive/#2	69 of 121	57.0%
<b>10</b>	Be Connected/Attuned/Fully Present	Relational/#2	69 of 122	56.6%
<b>11</b>	Good Listening Abilities	Cognitive/#3	64 of 121	52.9%
<b>12</b>	Be Flexible	Personal/#3	65 of 127	51.2%
<b>13</b>	Strong Evaluation/Assessment/ Interpretation Skills	Cognitive/#4	62 of 121	51.2%
<b>14</b>	Strong Self Awareness-Personal Insight	Personal/#4	64 of 127	50.4%
<b>15</b>	Possess Good Personal Boundaries	Personal/#5	61 of 126	48.4%
<b>16</b>	Understand Music as Non-Verbal Communication	Musical/#5	56 of 117	47.9%
<b>17</b>	Be Client Centered	Relational/#3	58 of 122	47.5%
<b>18</b>	Create a Safe Environment	Relational/#4	58 of 123	47.2%
<b>19</b>	Be Caring/Accepting/Value Client	Relational/#5	56 of 122	45.9%
<b>20</b>	Flexible Thinking	Cognitive/#5	54 of 121	44.6%

## Section II: Training of Music Therapist Personal Attributes.

Section II sought to assess the level of emphasis music therapy educators and clinical trainers placed on fostering personal attributes within the education and clinical training of music therapy students. Survey participants were required to score each of 10 statements according to a five-point Likert rating scale ranging from one (strongly disagree) to five (strongly agree). Table 8 presents the responses per category, Likert score, and standard deviation for each question.

Table 8.

### *Ratings for Training of Music Therapist Personal Attributes Statements*

Question	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Likert Score	Std Dev
<b>15. It is important and necessary to address personal attributes and demeanor in training music therapy students/interns.</b>	3	0	3	35	78	4.6	0.8
<b>16. In selecting students/ interns for my program, I evaluate personal attributes and relational abilities as part of the admission process. (6=NA)</b>	3	3	7	32	68	4.4	0.9
<b>17. Students are expected to possess good relationship building skills before entering my program.</b>	2	8	26	54	27	3.8	0.9
<b>18. Discussion of personal attributes and demeanor is incorporated into my education/clinical training process.</b>	1	0	4	48	64	4.5	0.6
<b>19. Clearly delineated expectations about how music therapy students/ interns are to employ appropriate personal attributes when interacting with clients.</b>	0	0	7	54	57	4.4	0.6

<b>20. I regularly model appropriate relationship building skills for my students/interns.</b>	1	0	5	33	80	4.6	0.7
<b>21. The course curriculum/internship protocols where I work incorporate the teaching of relationship building.</b>	0	6	18	62	33	4.0	0.8
<b>22. My students/interns are provided with formal opportunities to practice relationship building skills during class, supervision, peer group, or other settings.</b>	0	3	19	49	48	4.2	0.8
<b>23. Relationship building skills are expressly taught before music therapy students/interns are allowed to engage in direct therapy with clients.</b>	2	33	35	39	10	3.2	1.0
<b>24. I consider personal attributes and relationship building skills to be important for the future success of music therapy students.</b>	0	0	3	44	72	4.6	0.5

As indicated in Table 8, the highest response rates occurred in the “Agree” and “Strongly Agree” categories for eight out of the ten questions. These two categories combined to produce greater than >90% agreement among respondents for five out of the ten statements. Specifically, 97.5% of respondents deemed possessing personal attributes that foster relationship building to be important for future music therapist success (0% disagreement; 2.5% neutral), 95.7% signified that they incorporated discussion of personal attributes during student training (0.9% strongly disagreed; 3.4% neutral), and 94.96% agreed that it was important to address personal attributes and demeanor with students (2.5% strongly disagreed; 2.5% neutral). In addition, 94.9% indicated that they regularly modeled relationship building skills for students (0.8% strongly disagreed; 4.2% neutral) and 94.1% denoted that they expressly delineated expectations of how

students were to employ appropriate personal attributes when interacting with clients (0% disagreement; 5.9% neutral).

The remaining five statements produced less uniform agreement. While 84.0% of responders agreed that they evaluated potential students' personal attributes and relational abilities prior to admission to their program, this statement also produced six "not applicable" responses (5.0%; anecdotal comments indicated no control over admissions) as well as a combined 10.9% neutral or disagreement return. Provision of formal opportunities for students to practice relationship building skills produced 81.5% combined agreement, 16.0% neutral response, and 2.5% disagreement. Moreover, only 79.8% of those surveyed designated that they incorporated relationship building instruction into their education or clinical training processes (5.0% disagreed; 15.1% neutral).

The final two statements produced the lowest concurrence levels. Only 69.3% of respondents agreed that students or interns were expected to possess good relationship building skills before entering their programs. Combined disagreement levels stood at 8.5% while 22.2% gave neutral responses. The noticeably lower 3.8 Likert average indicated far less educator or clinical trainer agreement with a pre-requisite relationship building skill expectation.

However, the lowest agreement level, by far, was produced in response to the statement querying whether relationship building skills were expressly taught prior to students' direct client contact. Only 41.2% of respondents agreed with this statement, while neutral as well as combined disagreement each stood at 29.4%. This was the only

statement within the Section II Training Questions where neutral and negative sentiment outweighed participant agreement.

Nonetheless, overall agreement with the cited facets of training relationship building skills remained quite high across all 119 Section II respondents, producing a composite mean Likert score of 4.23 ( $R = 3.2-4.6$ ). Only two questions scored below 4.0—3.8 for pre-requisite relational abilities and 3.2 for teaching relationship-building prior to client contact. In summarizing total responses across all 10 statements, 987 of the recorded 1185 responses (adjusted for five skipped responses in questions #17, 18, & 19), or 83.3%, fell within the two agreement categories. Of these, 537 or 45.3% fell in the Strongly Agree category. These data indicated significant concurrence among music therapy educators and clinical trainers about the importance of fostering appropriate personal attributes and relational skills in music therapy students and interns.

### **Section III: The Music Therapy Education and Clinical Training Process**

Results for the final section of the survey were compiled discretely for the two sets of questions specifically addressed to music therapy educators or clinical trainers. All participants then responded to the survey's final question and comments section; these results were tabulated for the respondent group as a whole.

**The music therapy education process:** Forty-nine educator participants completed six multi-part questions about the general education process for music therapy students (See Appendix D for full content). Results are presented below:

***Question #26: Importance ascribed to incorporating development of interpersonal and relationship building expertise in music therapy students:*** Response to a five-point Likert rating scale (Not Important at All-Highly Important) proved



strongly positive. Forty-five of 49 educators (91.8%) designated development of these skills as Highly Important while three (6.1%) selected Somewhat Important with one neutral response (2.0%) recorded. These three categories combined produced 100% of the responses. Negative responses stood at zero level.

***Question #27: Formal addressing of personal attributes and relationship building within music therapy coursework.*** In response to this multi-part question, 44 educators (89.8%) indicated “yes” that personal attributes and relationship building were formally addressed within educational coursework. Five respondents (10.2%) chose “no.”

*“Yes” responses.* Those who responded “yes” were asked to list the three most prominent courses in their curriculums where attributes and relational skills were formally addressed. This open-ended question produced 124 widely varying responses which, when qualitatively analyzed, coalesced around the following categories: music therapy methods courses (54 entries), clinicals & practicum (47 entries), music courses (12 entries), ethics or psychology courses (8 entries), and generic-nonspecific responses (3 entries). The data strongly indicated that addressing relational skills and personal attributes primarily occurred either within methods courses (43.5%) or during actual field experiences (37.1%). Combined, these two curricular areas comprised 80.6% of the formal location responses.

It must be noted that the diverse terminology contained in these course descriptions necessitated fairly general classification. In no way was the researcher able to determine exact content or emphasis from the listed course titles. Those that included “music therapy” in the title were deemed methods courses, while titles that contained the terms clinical, fieldwork, practicum, or internship were designated as clinicals or

practicum. Titles considered music courses contained musical terminology (e.g., improvisation) while those designated psychology or ethics courses contained those specific words in their titles as well. The non-specificity of the remaining three course entries—“sophomore classes,” “documentation,” and “senior level fall courses”—disallowed any ability to classify them into more specific categories.

Figure 3. Techniques for developing students’ personal and relational abilities

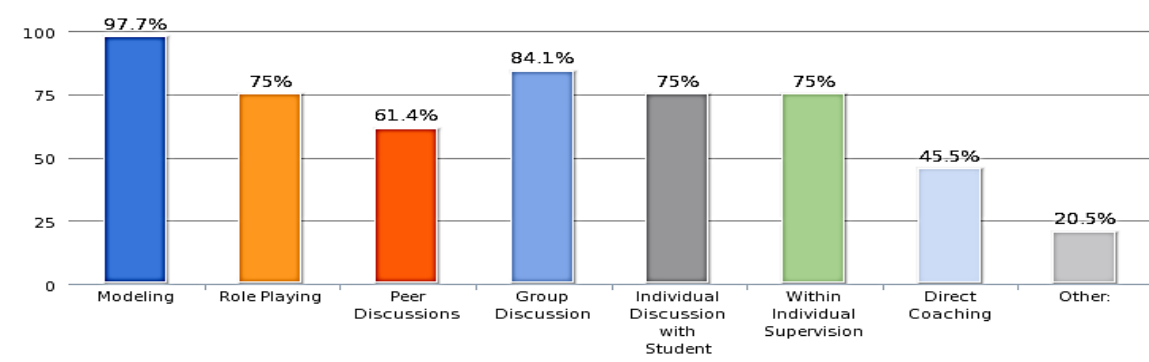


Figure 3. Music therapy educators chosen techniques for developing students’ personal attributes and relationship building skills.

The “yes” respondents were then asked to delineate their preferred instructional strategies for addressing the development of students’ personal attributes and relationship building skills in their classrooms (See Figure 3). Forty-four respondents answered this multiple-part question. By far, modeling was the most frequently cited teaching strategy with 43 out of 44 respondents (97.7%) indicating use of this technique. Group discussion was employed by 37 educators (84.1%) while role playing, individual discussion with students, and individual supervision each garnered 33 responses (75.0%). Peer discussion (27 responses/61.4%), direct coaching (20 responses/45.5%) and “other” (9 responses/20.5%—only one specified answer: “students practice in dyads”) attained less prominence amongst teaching techniques. Of interest, three of the top five selections

represented group delivery strategies, presumably due to ease of application in a classroom setting.

*“No” responses:* Those who indicated that relational abilities and personal attributes were not formally addressed in their setting were asked if informal practice opportunities were made available. Though only five participants initially answered “no” to Question #27, eight respondents—presumably three from the “yes” group—replied to this question. Of this group, seven (87.5%) indicated “yes” to provision of informal practice opportunities with only one “no” response (12.5%). Thirty-seven informal practice settings were listed which, though varied, coalesced around the following categories:

1. Advising/individual supervision (13 responses)
2. Class setting/discussion settings (8 responses)
3. Co-curriculars/music therapy club (4 responses)
4. Direct personal counseling (3 responses)
5. Formal evaluations (2 responses)
5. Other (3 responses: informal student questions; active listening homework; improvising in pairs or groups)

Overall results indicated that informal practice opportunities most often took place either during advising/individual supervision or within class/discussion settings. Combined, these two categories contained 21 of the 37 responses (56.8%).

Figure 4 presents the results for the final four educator questions (#s 28-31):

Figure 4. Educator Questions #28-31: Assistance; Recognition; Emphasis; Success

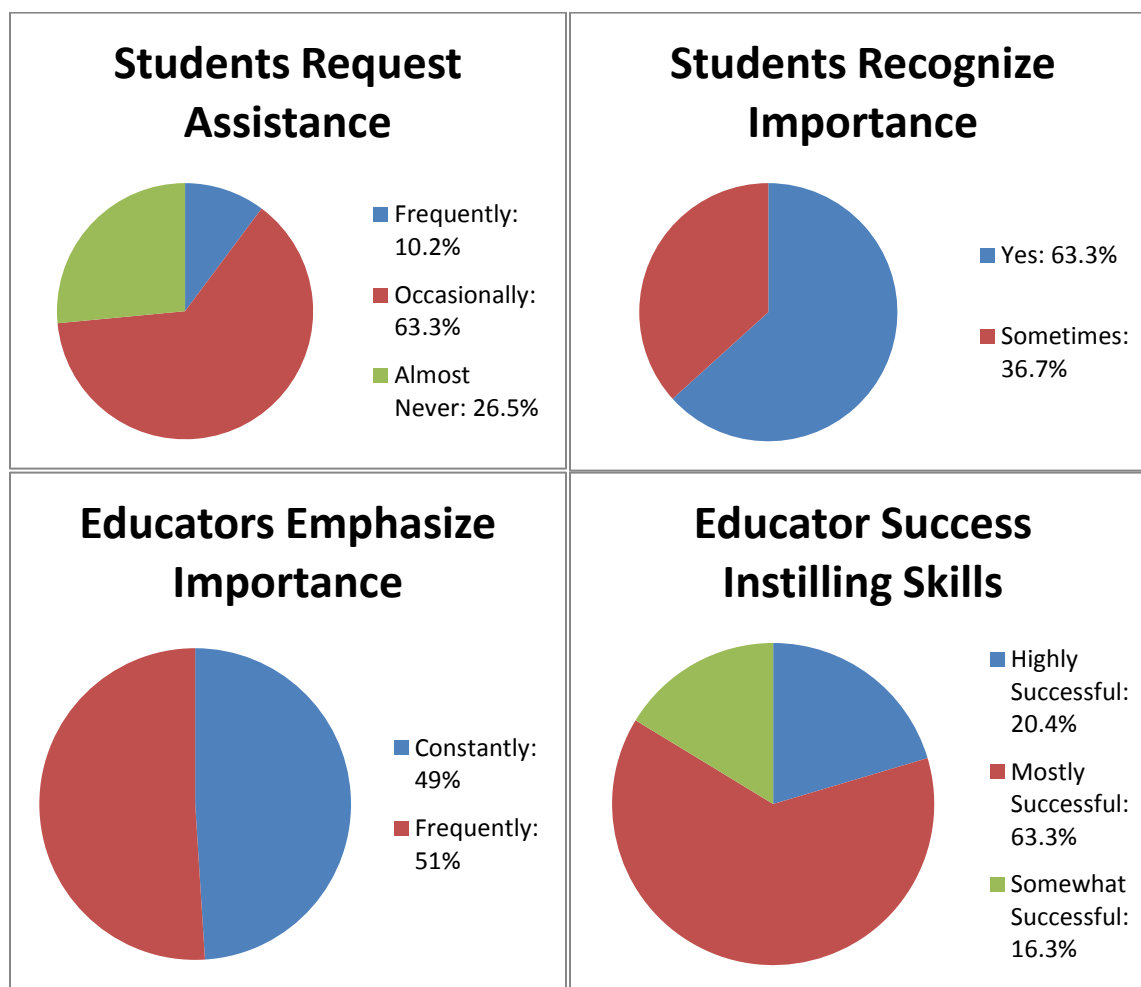


Figure 4. Response results for questions #28-31: Assistance; Recognition; Emphasis; Success. Percentage scores for delineated categories are presented for each question.

**Question #28. Frequency that students request assistance with developing relationship building expertise.** When asked how frequently students sought assistance with relationship building skills, 30 of 48 educators (63.3%) responded “occasionally,” 13 selected “almost never” (26.5%), and only five respondents indicated “frequently” (10.2%) as depicted in Figure 4. Thus, 43 out of 48 participants specified that this was not an area students sought assistance with very often. These data appear to indicate that developing this capacity does not seem to be foremost in students’ minds and may

possibly indicate that relationship building skills are not actually an area of significant focus in the education process.

*Question #29. Student recognition of the importance of possessing strong relationship building skills; Question #30. Frequency of educator emphasis on the importance of a music therapist's personal demeanor in building appropriate therapeutic relationships with clients; Question #31. Educator perception of success in instilling strong relationship building skills in students.* The potential lack of emphasis on relational abilities seems to be further supported by the responses to whether students appear to recognize the importance of possessing strong relationship building skills. Only 30 of the 48 educator participants (62.5%) indicated 'yes' to this question with 18 (37.5%) responding "sometimes." Yet, comparing these results with Question #15's strong agreement (95.7%) with the importance of addressing personal attributes and demeanor in student training may indicate a discrepancy between educator perception and actual practice. Moreover, when asked how often they emphasized the significance of a music therapist's personal demeanor, all 48 educators responded positively—23 indicating "constantly" (47.9%) and the remaining 25 choosing "frequently" (52.1%). In addition, 83.3% of educators reported being "highly successful" or "mostly successful" in instilling strong relationship building skills in their students while none reported being unsuccessful. These findings again support a possible incongruity between educators' perceived emphasis on these skills and student understanding of their importance.

**The clinical training process.** Figure 5 depicts the results for the first four questions about the preparation of music therapy interns as addressed by the 68 self-identified clinical trainers (See Appendix D for specific content).

Figure 5. Intern Training Questions #32-35: Importance of relational skill development; Expectation of skill possession; Assessment of skills; Formal address of relational skills

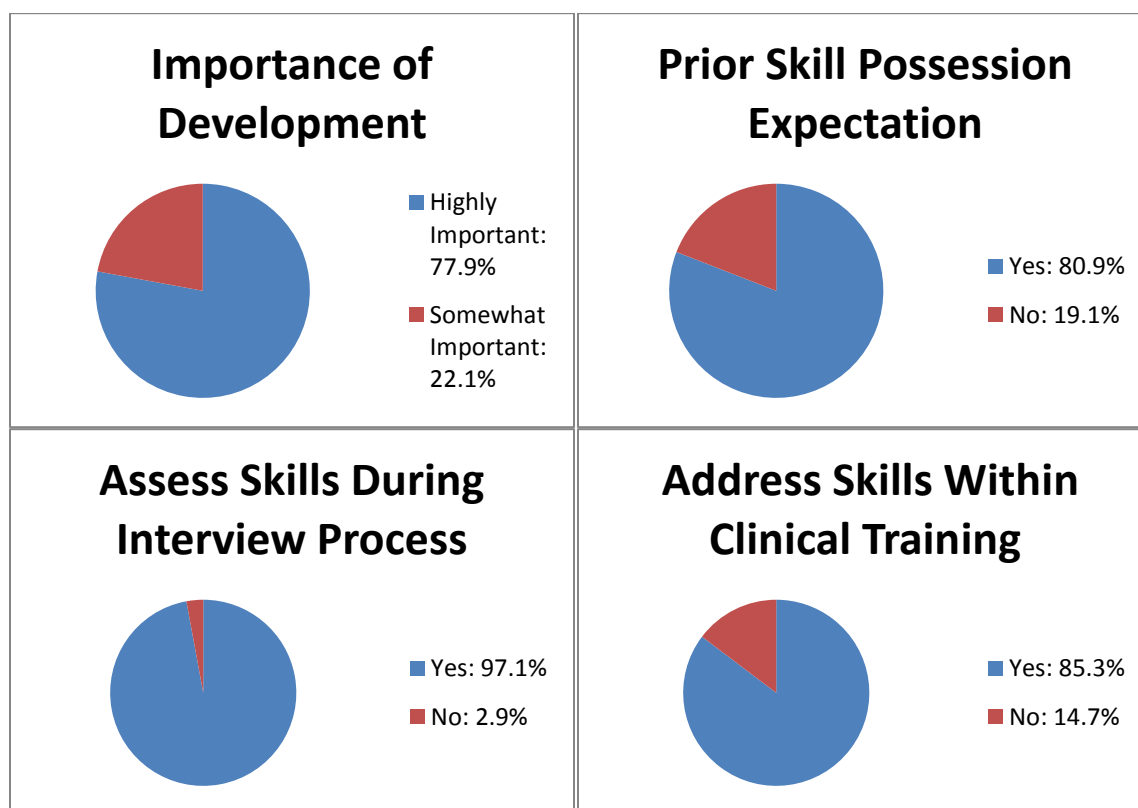


Figure 5. Percentage of agreement with intern training questions #32-35: importance of relational skill development; expectation of skill possession; assessment of skills; formal addressing of relational skills.

**Question #32. Importance of incorporating development of interpersonal and relationship building skills within intern training.** Level of importance clinical trainers ascribed to developing interns' interpersonal and relationship building skills showed strong positive response. On a five point Likert rating scale (Highly important-Not important at all), 53 of the 68 clinical trainers (77.9%) described these skills as "highly important" and the remaining 15 respondents selected "somewhat important."

Cumulatively, clinical trainers demonstrated 100% agreement as to the importance of

emphasizing these skills with no neutral or negative responses recorded. These results were congruent with the music therapy educators' response in this area.

***Question #33. Expectation that students entering internship already possess strong relational abilities.*** Interestingly, when clinical trainers were asked whether they expected students to possess strong relational abilities before entering internship, 55 respondents (80.9%) indicated “yes” with only 13 “no” responses recorded. This result appears to indicate that clinical trainers felt strongly that relational skill development should occur within the education process and that students should attain these abilities prior to internship.

***Question #34. Assessing applicants' interpersonal/relationship building abilities during interview process.*** Similarly, strong affirmative response was obtained when the clinical trainers were asked whether they attempted to assess interpersonal and relational skills as part of the intern interview process. Overwhelmingly, 66 respondents (97.1%) indicated “yes” with only 2 dissenting responses, again indicating the importance clinical trainers placed on pre-requisite presence of intern applicants' relational skills.

***Question # 35. Formal addressing of personal attributes and relationship building within intern training.*** Clinical trainers were then asked to indicate whether they formally addressed personal attributes and relationship building in their training of interns. Here again, strong positive response was evinced, with 58 of the 68 clinical trainers (85.3%) indicating “yes” and only 10 (14.7%) responding “no.”

The “yes” respondents were then asked to specify how they addressed development of personal attributes and relationship building during intern training. Figure 6 presents the results of the 62 responses to this question. The three most

prominent training strategies cited were Modeling and During Supervision (58 responses/ 93.6% each) as well as Discussion with Intern (57 responses/ 91.9%). The remaining cited strategies—role playing (25 responses), peer discussion (18 responses), direct coaching (18 responses), group discussion (15 responses), and other (5 responses with three specified: “company’s service behavior expectations;” “creative outlets;” “written monthly report to hospital’s program director”) all remained well below 50% levels ( $R = 8.1\text{--}40.3\%$ ). Interestingly, similar to the educators, modeling was again cited as the most highly utilized teaching strategy. However, during intern training, greater emphasis was placed on individual interventions (e.g., individual discussion with intern), which may reflect the differing instructional models employed when individually training interns versus educating students in groups.

Figure 6. Clinical Trainer Techniques for Developing Intern Relational Skills

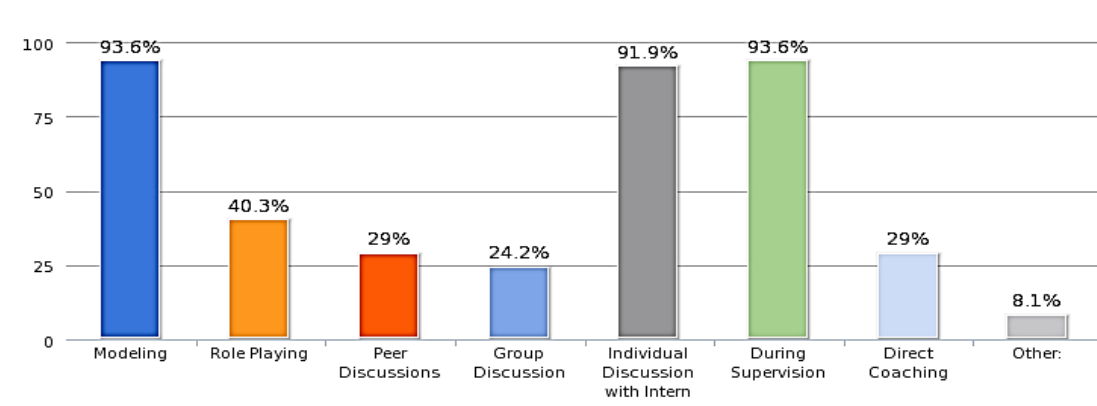


Figure 6. Clinical trainers’ preferred techniques for developing interns’ essential personal attributes and relationship building skills by percentage.

***Question #36. Success in instilling strong relationship building skills in interns.***

The final Likert scale question for clinical trainers pertained to the level of success they achieved in fostering interns’ relational skills. Similar to their educator counterparts,



clinical trainers reported overall general success in this area, with 10 (14.7%) indicating “high” success, 50 (73.5%) citing being “mostly successful” and 8 (11.8%) specifying “somewhat successful.” Here again, zero unsuccessful responses were recorded.

Figure 7. Comparison of Educators and Clinical Trainers Reported Success Rates

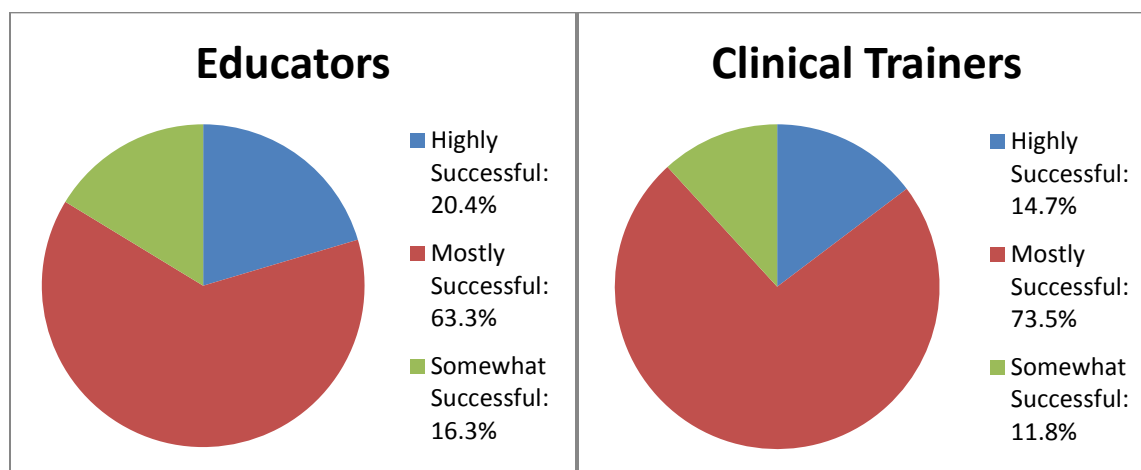


Figure 7. Comparison of level of success in instilling strong relationship building skills in students versus interns as reported by music therapy educators and clinical trainers.

Figure 7 presents a comparison of educators and clinical trainers’ perceived level of success in fostering relationship building skills in students or interns. While the two graphs appear largely similar and strongly skewed toward positive outcomes, the percentage of Highly Successful responses was greater for the educators while clinical trainers’ Mostly Successful ratings exceeded that of their educator counterparts. It may be that these disparities reflect real world realities versus the presumably more theoretical learning environments of classrooms.

**Final thoughts.** All survey participants were asked to respond to this final question: *Do you feel that it is possible to foster appropriate personal attributes and relational abilities in your music therapy students/interns?* Response to this question was

a resounding “yes.” Of the 116 question answers, 113 (97.4%) responded affirmatively with only 3 dissenting responses (2.6%).

**“Yes” responses.** Those that answered “yes” were then asked to list their three most successful strategies for fostering these skills. The 299 widely varying responses were analyzed qualitatively to discern thematic alignment. Fourteen general categories were identified along with four non-specific (i.e., “other”) responses. Rank ordered results are presented in Table 9.

Table 9

*Ranked strategies for fostering personal attributes and relational abilities*

Rank Order	Category	Number of Responses
1	Modeling	69
2	Discussion	43
3	Feedback	39
4	Supervision	36
5	Role playing	32
6	Experiential Learning/Practice	16
7	Classroom/Educational experiences	14
8	Direct coaching/Instruction	13
9	Journaling/Self-Assessment	9
10	Videotaping	5
11	Assessments/Evaluations	5
12	Observation by student/intern	4
13	Personal counseling	2
14	Creative/Musical experiences	2
Other	Identify relationships between client and intern; Encourage friendly professional relationships with staff ; Be genuine; Have fun	

Once again, modeling far outweighed other strategies with discussion, feedback, supervision, and role playing rounding out the five most frequently cited techniques. All other cited strategies received significantly lower emphasis.

**“No” responses.** This final question’s “no” respondents offered only a few detailed reasons for why they felt it was not possible to train personal attributes and relational skills. Of the five reasons cited, four supported attaining these skills prior to internship or academic acceptance or stated that these skills can only be built upon: (a) “These skills are able to be built upon, but not taught in my opinion; (b) “If they don’t possess it already, not going to learn it in internship;” (c) “They should already possess these abilities prior to internship;” (d) “Music therapy students should be screened for their relational abilities prior to acceptance to a university as it is not usually something that can be taught outright if there isn’t a natural ability; it can just be improved.” Conversely, the remaining response actually supported the teaching of these attributes: “It is too important not to teach these skills therefore it is never not possible.”

**Open-ended comments.** Survey participants were provided with a final opportunity to offer any additional thoughts on the topic of training essential music therapist attributes. Forty-six participants chose to add further remarks or multiple comments which were analyzed for thematic similarity. These responses coalesced around the following rank-ordered topic areas:

1. Addressing personal attributes and relationship building skills during the education process prior to internship (10 responses)
2. Acquisition of these attributes is a developmental process (9 responses)
3. Personal issues interfere with development of relational skills (8 responses)

4. This is an important research topic for the music therapy profession (8 responses)
5. Most students can learn/be taught these skills (5 responses)
6. These skills are hard to teach/difficult to assess (2 responses)
7. Five non-specific comments pertaining to survey format, specific techniques, and the need to address attributes for both music & verbal interaction

Since this commentary added to the richness of the survey respondents' contributions to this research endeavor, excerpts have been included here. First, it was obvious that the clinical training community felt the need for students to have acquired essential personal attributes and relationship-building skills prior to entering clinical training:

- (1) "Internship is a time to transition to becoming a professional and six months is short to be learning new skills; instead, skill[s] should be applied and practiced;"
- (2) "Although we work on this during internship, I feel that interns must have developed the essential personal attributes and relational skills before their internship. If they don't have the potential to develop these attributes, ideally, they should have been advised to pursue a different field. The success of our field depends on it."

Many remarked about the ability of students to learn and refine these skills and attributes:

- (1) "My experience has been that you can help a student/intern 'come out of their shell' if they have personal insight and are open to feedback;"
- (2) "It's a developmental process —takes experience, wisdom, patience, and the ability to be authentically real...";
- (3) "While I feel that there are ways to develop personal

attributes and relational skills, I feel that many interns fall on a continuum-not a 'have it' or 'don't have it'...:

Others contributors noted the difficulties surrounding the teaching of these skills:

(1) "There are other factors as well—the emotional readiness...overall cognitive abilities...willingness to try or accept coaching concepts;" (2) "It is somewhat impossible to control for an intern's upbringing, home environment, and prior life experiences! It is also difficult to make an estimation of these attributes and skills in a prospective intern whom one is meeting just once for the first time;" (3) "Though we try very hard to instill these skills/attributes, I think that sometimes traditional undergraduate students are just not mature enough yet to grasp these skills."

Several respondents cited the importance of possessing these attributes and skills:

(1) "I feel the relational aspects of being a therapist...is the absolute fundamental to MT; without that strong relationship, the rest of MT can simply be forgotten; it is crucial and I view it as the most important part of the therapeutic process;" (2) "Students need to learn and know that creating relationship is a large part of the therapeutic process and can have a significant impact on the level of the client's investment in the music therapy process and experience."

Lastly, a wide range of comments addressed the importance of this research topic:

(1) "Thank you for examining this topic...I believe we have an obligation to constantly be asking ourselves these questions, given our ethical responsibility to all those who our graduates will encounter in a professional setting;" (2) "Perhaps if there were more defined competencies on this topic that an educator could use

as criteria for accepting a student, that would help protect future music therapy clients and insure the success of the MT students and MT programs. I'm so glad that you have chosen to address this topic in your research. It is very important!"

### **Overall Conclusions Pertaining to Essential Music Therapist Attributes**

The results from this two-phase investigation demonstrated strong consensus about the essential personal attributes and relational abilities that an effective children's music therapist should possess. The data provided clear indication that participating clinicians, music therapy educators and clinical trainers not only deemed it important and necessary to train relational attributes, but that they were currently addressing these qualities in the training of music therapy students.

Specifically, the Phase One qualitative analysis of interviews with five children's music therapists revealed high level participant agreement about the components of establishing therapeutic alliances with children—the music therapist, working with children, settings for the work, and the music—all of which serve as foundations for the music therapy relationship. Despite the diversity among settings and child populations these clinicians addressed, their descriptions of their therapeutic processes proved quite similar as did the terminology they used to delineate the elements of relationship-building. Moreover, cross comparison of the discourse pertaining to essential music therapist attributes again evinced high levels of agreement among these clinicians. The data appear to indicate that the elemental components of effecting positive therapeutic alliances with children and the personal attributes a music therapist employs to engender these relationships transcend settings, child populations, and delivery models.

The Phase Two survey demonstrated further support for the importance of the delineated essential personal attributes and relational skills among music therapy educators and clinical trainers. Of the total 54 personal qualities, relational qualities, cognitive abilities, and musical attributes assayed, 48 (88.9%) received >90% overall importance agreement. In addition, survey respondents strongly attested to the necessity of training personal attributes, generally indicating that these qualities are currently address within their respective education and clinical training programs. They also provided specifics of where and how this instruction occurred within their curriculums or training protocols. Of greatest note was the pervasive belief (94.7%) that these personal attributes can be trained. Discussion of these results, their relationship to the literature, and the overall significance of these findings will be presented in Chapter Five.

## **CHAPTER 5**

### **Discussion**

The purpose of this study was to illuminate the personal attributes of a music therapist that are essential for engendering effective therapeutic relationships with children and to explore whether and how these qualities are currently addressed during the training of music therapy students. The overarching goals of this dissertation were to begin identifying the aspects of relationship-building that go beyond skills, techniques, and theoretical orientation and to open a discussion about how to best address training of the person of the music therapist.

This inquiry took the form of a sequential mixed method design. Analytic cross-comparison of Phase One phenomenological interviews with five experienced clinicians sought to discern a music therapist's essential attributes for relationship building with children. These findings then served as the basis for the Phase Two quantitative survey of music therapy educators and clinical trainers. The following research questions were addressed:

1. What are the personal attributes that experienced music therapists see as essential to their ability to engender effective therapeutic liaison with children?
2. What are the important components of relationship building as delineated by experienced music therapists?
3. To what level do music therapy educators and clinical trainers agree with the importance of these delineated personal attributes?
4. How is development of these essential personal attributes currently incorporated into the training of music therapy students and interns?



5. Do music therapy educators and clinical trainers think personal attributes are amenable to training? If so, how; if not, why not?

This chapter will offer discussion of the Phase One and Phase Two results.

Considerations, limitations, and value of the outcomes will be followed by re-examining the assumptions that guided this research. Implications for future inquiry and general conclusions will then follow.

*“I believe that one of the vast beauties of the human condition is to realize that our ways of interpreting language are variable and ever changing. It is our language that allows us a means of defining and processing what occurs in an experience” (Loewy, 1994, p. 33)*

## **Phase One**

Phase One sought to address the first two research questions: (1) interviewee perspectives about essential personal attributes and (2) relational components central to therapeutic alliance with children. The interviews provided lived experience insight into how the five experienced therapists establish relationships with a range of children. The interview data was analyzed discretely in an effort to maintain individual focus on each case, as described by Bruschia (2005):

In a case oriented analysis...the researcher looks at...the themes that occur within each case, one at a time, and only in reference to itself. Once every case has been understood on its own terms...the researcher may then opt to do a cross case analysis” (p.181).

Journaling and bracketing techniques (Holstein & Gubrium, 2005, p 496) were applied to ensure that each interview was addressed according to its own merit, which was deemed

especially important given that the researcher served both as interviewer and analyst in this investigation.

It was interesting to witness the distinct participant voices and the portions of the discussion where each clinician placed their emphasis. For example, ME spoke most extensively about the young children themselves and the joy she derived from witnessing their spontaneity and wonder. Conversely, GL underscored the psychodynamic aspects of working with children's emotional issues. CT focused on the effects of a hospital environment on children. BR and AG both highlighted behavioral techniques and structure in their work; however, BR accentuated a humanistic, improvisational style while AG emphasized a process level approach.

Nonetheless, cross-comparison of the participants' remarks about relationship building exposed similarities which allowed their ideas to be coalesced along the same thematic lines (i.e., music therapist; children; setting; the music). Notably, relationship figured prominently in these descriptions of therapeutic efficacy and aligned with previous research findings in qualitative music therapy, child development, as well as counseling discourse (e.g., Blow et al., 2007; Brescia, 2004; Kochanska & Aksan, 1995) and paralleled the writings of relational theorists (e.g., Miller & Stiver, 1997).

In addition, all five participants most strongly accentuated the same attributes domains —personal qualities and relational qualities—as evinced by the higher response concentrations in these areas (53 & 58 respectively vs. 40 cognitive & 35 music abilities). The cited personal attributes (passion for the work; flexibility; self-assurance; empathy; patience; open-mindedness; a positive-playful-enthusiastic-dynamic-approachable demeanor) closely correlated with effective teacher characteristics cited in education

research (Barrett, 1991; Colker, 2007; Oleson, 1997; Shanoski & Hranitz, 1999; Soulis, 2009; Wong, 1994) and aligned with the personality profiles of college music students identified by Steele and Young (2008).

The five interviewees also identified similar qualities as essential relational attributes—most notably relationship based on respect for the child. This finding correlated with Mook's (1982) earlier investigation which identified respect and empathy as foundational components of counseling alliance with children. The child-centered relational elements the clinicians advanced—attuned physical presence; valuing; empowerment; trust; supportive nonverbal expression; collaboration; fostering independence—promoted a safe, nurturing, and growth-engendering liaison as the basis for the work. Here again, parallels were demonstrated with the alliance focus cited in counseling discourse (e.g., Dunkle & Friedlander, 1996; Lieber et al., 2010), the nurturing qualities of positive regard, support, facilitation, and empathy identified by psychology researchers (e.g., Farber & Lane, 2001; Kazdin et al., 2005; Patterson & Forgatch, 1985; Schacht et al., 1989), and the attunement studies of Adamson et al., (2009), Gordon and Toukmanian (2002), and Tickle-Degnen and Rosenthal (1990).

Similarly, cognitive abilities that drew strongest participant consensus—observation, flexibility, and individualization—corroborated with qualities identified by Xu and Gulosino (2006) whose research findings emphasized the importance of focusing on the behavioral aspects of teaching. Musically, the interviewees underscored their need to share music, use music in the service of others, and emphasize musical relationship in working with children. These results paralleled the survey findings of Madsen and Goins (2002) which indicated that college music therapy majors more frequently engaged in

service projects and focused on helping others. Importantly, the strength of response correlation relative to all these personal characteristics—both within and outside of the present inquiry—warrants attention in light of Thornton’s (2006) postulation that a supportive, responsive disposition can and should be taught.

Interestingly, the five interviewees’ descriptions of relationship-building elements proved very similar with the core ideas of respect, dignity, trust, safety, acceptance, valuing, connection, empowerment, communication, and humor being very closely allied. These terms also robustly correlated with the postulates of responsive classroom (e.g., Rimm-Kaufman & Chiu, 2007), play therapy (e.g., Bowers, 2009), and teacher characteristics research (e.g., Colker, 2007).

Analysis further revealed that these clinicians emphasized positives in their thinking (i.e., positive relationships; seeing the positives in children; a positive outlook) which aligned with Fowler’s (2006) findings that music therapists who remained in the field were able to focus on positives as a means of developing effective, long-term coping strategies. Like Milgram-Luterman (1999), who theorized that life-long learning is central to the development of music therapist expertise, all five participants highlighted the role that experience and continual learning played in their ability to be consistently supportive, flexible and responsive in their work with children. They spoke about welcoming the challenges the work presented and their continual desire to engage with these “puzzles.” Lastly, reminiscent of the philosophical posture of Buber (1970), all stressed a forward thinking stance and orientation toward the other—namely the children.

Overall, the Phase One qualitative inquiry results evinced considerable congruency of ideas among clinicians whose music therapy practices differed in location,

program emphases, and child populations. In contrast to the general paucity of relation-focused research in music therapy discourse, this consensus potentially speaks to the presence of a tacit body of knowledge about the parameters of fostering productive therapeutic alliances with children. Moreover, the alignment between these clinicians' understandings about relationship-building and findings from psychology, counseling, child development, and education literatures points to the need for the music therapy profession to better define this area of practice expertise.

**Phase one considerations and limitations.** Several issues, nonetheless, require address. First, in attempting to expose the interviewees' ideas, concepts, and lived experience, it quickly became apparent that rendering these understandings in language was imprecise at best. The fact that words remains perennially open to interpretation led to a number of semantic dilemmas. At times, though the terms offered by individual participants differed (e.g., enthusiastic vs. dynamic vs. animated), the referenced concept as supported by in their stories or descriptions proved to be much the same. While obtaining personal vocabulary definitions may have afforded more precise understanding of the interviewees' intended meanings, relying on context in many cases offered greater clarity.

In addition, the data outcomes may have been affected by the differing emphases interviewees placed on various topics of the discussion. While overall content often proved categorically similar, the age of the children being discussed, the extent of the special needs, or the location where clinicians worked (e.g., public school vs. hospital) did seem to affect where they focused their responses. For example, GL and CT spoke extensively about the effects of scheduling and setting on their ability to effectively treat

children while ME did not address this aspect to any extent. It may be that the needs of the particular children or the culture of their respective workplaces promoted a particular orientation to the material.

There also remains a question of bias. As noted, the researcher and interviewees possessed very similar backgrounds. All were Caucasian—which was understandable given the 13% minority status of the music therapy profession (AMTA, 2012). Like the researcher, three interviewees were licensed music teachers and two became music therapists only after completing a master's level equivalency program. Most possessed not only music therapy training but other experience (e.g., counseling, behavior management, music education) as well. Clinically, all had adopted an eclectic theoretical stance that moved beyond their behavioral music therapy training. Though many of these demographics were unknown to the investigator prior to participant selection, it cannot be denied that, in the process of applying purposive sampling, the researcher selected participants in some ways quite similar to herself. The potential remains that the similarity of ideas and themes derived from the interviews may have been influenced by this lack of diversity.

In addition, the researcher was in some way acquainted with all interviewees prior to the onset of the present study—not surprising in a profession numbering only about 5800 MT-BCs (CBMT, 2014). This familiarity, no doubt, provided a strong foundation for the mutual trust necessary for delving so deeply into the participants' personal process. However, the resulting conversations may have been slanted by this level of acquaintance.

It should also be noted that the age range of the participants (40s-60s) may have

affected the results. These music therapists were all trained during the period when objectivism and behaviorist methodology predominated in the United States as evidenced by the proliferation of behavioral studies in the music therapy literature (Furman, 1988; AMTA, 2000). It is feasible that younger clinicians do not carry this background and thus potentially possess different viewpoints. Alternately, it is possible that behavioral pedagogy, and any response style this methodology may potentially generate, aligns with music therapists who choose to focus on the developmental process of child learning.

Lastly, potential subjectivity brought to the process by the investigator herself must be acknowledged. Whenever a single individual assumes all research roles (i.e., interviewer, examiner, survey designer, analyst, author), logically, it would seem impossible to completely separate the person from the process. As noted by Wheeler and Kenney, “The qualitative researcher recognizes that the experiences being investigated are seen through the researcher’s eyes and heard through the researcher’s ears, and thus that they are shared in the researcher’s voice” (2005, p. 67). As a result, “the issue becomes not so much distance, objectivity, and neutrality as closeness, subjectivity, and engagement” (Tedlock, 2005, p. 467). Thus, despite the care taken to minimize these influences through application of bracketing (Holstein & Gubrium, 2005, p. 485), member checking review (Creswell, 2009, p. 191), reflective journaling, and inclusion of thick description and “illustration-by-example” participant quotes (Abrams, 2005, p. 250), it remains possible that the strong congruency found in the Phase One inquiry may have been influenced by researcher perception.

Nonetheless, these mitigating factors cannot totally negate the high level agreement observed among five practitioners whose personal backgrounds, physical

locations, work settings, and child populations varied widely. Moreover the correlation between the Phase One outcomes and research findings from related fields (e.g. counseling; education) further mitigates these concerns. Lastly, corroboration of these results by the music therapy educators and clinical trainers surveyed in Phase Two further supports their potential validity.

**Value of phase one outcomes.** It must be remembered that qualitative phenomenology, by design, offers only a momentary portrait of experiences occurring in time (Creswell, 2009, p. 193). However, the value of the Phase One outcomes rested in their ability to serve as the basis for the broader Phase Two survey of music therapy educators and clinical trainers.

## **Phase Two**

This phase sought to address the final three research questions—(3) potential agreement with Phase One findings, (4) current training practices, and (5) ability to train personal attributes. Survey return rates (48.27%; 132 of 261 potential respondents) proved more robust than the average 39.6 % draw for internet surveys cited by Thomas (2004, p. 124), potentially alluding to the importance respondents ascribed to the research topic.

**Agreement with phase one essential attributes findings.** Strong concurrence with the delineated essential music therapist attributes was witnessed in the surveyed educators' and clinical trainers' responses. All four domains garnered above 90% overall agreement (personal qualities, 93.46%; relational qualities, 97.39%; cognitive abilities, 99.46%; musical attributes, 94.05%) with a noticeably strong global average of 96.09%. Negative or neutral ratings remained negligible.



Significantly, only two of 54 listed attributes (both personal qualities) garnered < 80% agreement (happy-playful-fun loving-humorous demeanor, 78.5%; display commanding presence, 64.6%). Yet, even these qualities were deemed important by nearly two-thirds or more of those surveyed. Thus, the educators and clinical trainers overwhelmingly agreed with the importance of the essential attributes denoted by the interviewees. While this sample does not necessarily represent the views of all music therapists, the relatively close demographic correlation with the general AMTA membership—12.6 vs. 11% male; 93.7 vs. 89.7 % Caucasian (AMTA, 2013a)—lent credence to the potential validity of the obtained consensus.

Rank ordering of attributes within each domain proved quite interesting. The fairly wide percentage ranges across the top five choices in each domain—personal qualities ( $R = 48.4\text{--}71.69\%$ ); relational qualities ( $R = 45.9\text{--}84.4\%$ ); cognitive abilities ( $R = 44.6\text{--}66.9\%$ ); musical attributes ( $R = 59.3\text{--}77.96\%$ )—seems reasonable given the array of category choices ( $N = 11\text{--}16$ ) and the breadth of the participant sample. Of particular note, however, the top ranked attribute within each category (respect for clients, 84.4%; strong musicianship, 77.96%; nonjudgmental-accepting-empathetic, 71.69%; strong observational skills, 66.9%)—attained two-thirds to more than three-quarters majority agreement. Even the lowest top ranked attributes in each domain approached or exceeded general consensus (44.6–59.3%). The strength of response tendered by survey participants further corroborated the consensus with Phase One findings.

However, composite rankings of all four domains combined (See Table 7) proved most thought-provoking. Given the parity indicated by the equal selection of five

attributes from each domain, it appears that, similar to the Phase One clinicians, the surveyed music therapy educators and clinical trainers also placed equal weight on the four attributes domains. Moreover, four of the top 10 composite ranked selections were Musical Attributes, which alluded to the importance that survey participants—like their interview colleagues—placed on musical abilities as essential music therapist attributes.

**Training of music therapist personal attributes.** The survey's remaining sections addressed the current perceptions about and status of incorporating essential attributes and relationship-building instruction into the education of music therapy students. As noted by Weisz et al., (1987) therapist effectiveness is dependent upon more than technical expertise alone. After rating the importance of 10 general training statements, the participants were then divided by designation as educators or clinical trainers, with each group completing parallel question tracks.

**General training statements.** As indicated in Table 8, overall agreement with the 10 general training statements was strong—five >90% ( $R = 94.1-97.5\%$ ); three more  $\geq 80\%$  ( $R = 79.8-88.5\%$ ). Educators and clinical trainers strongly concurred that possessing appropriate personal attributes and relationship building skills was central to music therapists' success (97.5%). They also supported the need to address personal attributes and demeanor during student training (94.96%), indicated that personal attributes discussion was incorporated into their training curriculum (95.7%), specified that they regularly modeled appropriate relational skills for students (94.96%), and cited that they clearly stipulated students' need to utilize appropriate personal attributes and relational capacities when interacting with clients (94.1%).

Somewhat lower but still significantly positive agreement was seen in relation to

personal attributes and relational abilities being evaluated as part of admission (84%; 10.9% neutral), providing formal opportunities to practice relationship building skills (81.5%; 16% neutral), and incorporating the teaching of relationship building within their curriculums (79.8%; neutral response 15.1%). The increased neutral response level was notable, however. Conversely, the final two statements—students are expected to possess good relationship building skills before entering program (69.2%; neutral 22.2%) and relationship building skills are expressly taught before students engage in direct contact with clients (41.2%; 58.8% neutral/negative)—produced notably less agreement, significantly higher neutral or negative response, and were the only entries that received lower than 4.0 Likert scores. This last finding was supported in the play therapy literature where Allen, Folger, and Pehrsson (2007) described the importance of assisting play therapy intern in developing counseling relationships with children in the clinical setting.

These results appear to indicate that music therapy educators and clinical trainers felt strongly that future professional success was incumbent upon possessing appropriate personal attributes and relationship building skills and that these abilities should be addressed during training. Moreover, respondents indicated that these qualities were currently addressing within their programs, that they evaluated personal attributes as part of student admission, personally modeled these behaviors, discussed relationship building, provided opportunities for students to practice these skills, and clearly specified how students were to act during direct client contact.

Conversely, educators and clinical trainers more strongly disagreed that students should possess essential personal attributes and relationship building skills before entering their training programs and that these skills should be expressly taught before

students were allowed direct interaction with clients. These two findings appear to indicate that educators and clinical trainers expect to teach these abilities as part of the music therapy student training and that acquiring these attributes will most likely occur during direct client contact.

Notably, a discernable level of ‘not applicable’ (5.0%) as well as a combined 10.9% neutral/disagreement return was evidenced for the statement about assessing attributes as part of program admission. This finding quite possibly points to a lack of educator control over the admission process. (Indeed, several anecdotal comments cited this reality.) In addition, while respondents noted the importance of training these abilities, only 79.8% actually agreed that relationship building was incorporated into their training programs. Nonetheless, composite agreement (83.3%) with the 10 general training statements seems to indicate educator and clinical trainer concurrence with the importance of possessing appropriate personal attributes and the necessity and current practice of addressing these qualities during music therapy training.

***Educator questions.*** Forty-nine educators answered six multi-part questions assaying their perceptions about whether and how interpersonal and relationship building training was incorporated within their curriculums. The importance of providing attributes and relationship instruction received strong educator support with 48 respondents indicating overall agreement (97.9%) and only one neutral reaction (2.1%). Thus, similar to the general training responses, educators deemed these qualities very important for music therapy students to acquire.

Similarly, 89.8% of educators indicated that they formally addressed personal attributes for relationship building with the predominant curriculum venues cited as

music therapy methods courses and clinical practicum (combined 80.6%). Modeling (97.7%) and group discussion (84.1%) were most prominently featured as formal instructional strategies along with role playing, individual discussion with students, and individual supervision (75% each). Peer discussion and direct coaching were also specified, but to a much lower extent. Understandably, many of these approaches represent group instruction methods which presumably align more easily with typical college teaching paradigms.

Only five educators indicated that attributes and relational skills were not formally addressed within their curriculums. Interestingly, these respondents listed informal opportunities for addressing these skills as: during individual advising-supervision, class discussion, music therapy club, counseling, and structured evaluations—all seemingly somewhat formal settings. Again, these settings appear to align with typical college structures. Thus, despite a lack of formal curriculum inclusion, fostering personal attributes and relational skills still appeared to be addressed in some fashion by these minority respondents.

However, when the questioning turned to perceived student reactions, notably different results ensued. While educators indicated that they strongly emphasized essential attributes and relational skills, student response may suggest otherwise. When asked how frequently students requested assistance with developing relationship building expertise, the overwhelming majority (43 of 49) specified “occasionally” (30), or “almost never” (13). Thus, educators indicated that this was not an area where students often sought assistance. Equally troubling, when queried as to whether they thought that students recognized the importance of possessing strong relationship building skills, only

62.5% of educators indicated ‘yes’ with a rather high 37.5% responding “sometimes.”

Nonetheless, educators perceived that they were accentuating essential attributes and relational abilities as evidenced by their decisive response to how often they emphasized a music therapist’s personal demeanor—23 indicated “constantly” (47.9%) and the remaining 25 chose “frequently” (52.1%). In addition, 83.3% of these educators reported being “highly” or “mostly” successful in instilling strong relationship building skills in their students while (not surprisingly) none reported being any less than “somewhat successful.” Moreover, general training responses had previously demonstrated strong agreement that acquisition of essential personal attributes and relational skills was vital to music therapy students’ future professional success.

These findings potentially paint a sharp contrast between educator perception and student understanding. It appears that an incongruity may be present between what educators believe they are imparting and what students perceive is being emphasized in their training. As indicated by students’ pervasive dearth of questioning about personal attributes and rather lackluster educator response as to whether students recognize the importance of possessing relationship building skills, the reality may well be that development of essential personal attributes is subjugated to acquisition of specific skills and methodology within curriculum promotion. In an educational process that only tangentially specifies personal attributes (Competency 9.1-3) within the mandated 117 professional competencies that must be acquired during undergraduate tenure (AMTA, 2013), it is highly possible that personal and relational skills, in actuality, may only garner peripheral focus. Indeed, Bruscia had already spoken to this reality:

In perusing the lists of competencies, it is easy to become overwhelmed by the

staggering amount of knowledge, skills, and ability that need to be learned to enter the profession. For music therapy educators, these lists raise some very fundamental questions: to what extent is it even possible to teach all of the competencies needed within the allotted time period, and at what breadth and depth can any of them be learned? (1987, p. 17)

***Clinical trainer questions.*** Congruent with their educator counterparts, 100% of the 68 self-identified clinical trainer respondents acknowledged the importance of developing interns' essential personal attributes and relational skills (77.9% highly/22.1% somewhat important). In addition, 97.1% reported assessing for the presence of relational skills and essential attributes during their intake process. However, clinical trainers strongly attested (80.9%) that they felt these skills should be acquired prior to internship. [It should be noted that within graduate music therapy equivalency training, clinical practica often occur simultaneously with coursework in contrast to the sequential undergraduate education and training process seemingly indicated by the surveyed clinical trainers responses in this study.)

Nonetheless, 85.3% of trainers indicated that they continued to formally address personal attributes and relational skills during student internship. Modeling (93.6%), supervision (93.6%), and discussion (91.9%) were cited as the most prominent teaching strategies. Role playing, peer discussion, direct coaching, and group discussion were also cited, though at > 50% levels. Of note, most of these instructional techniques seemed to be more one-to-one oriented than cited educator strategies, presumably due to the more individualized nature of intern training.

The final clinical training question addressed success with instilling strong

relationship building capacities in interns. While reporting overall success (14.7% highly/73.5% mostly/11.8% somewhat successful), it was interesting to note that clinical trainer responses were more strongly skewed toward median success levels than their educator counterparts (See Figure 7). It could be postulated that this downward shift may perhaps be indicative of real world clinical realities versus more simulated classroom success.

**The final question.** *Can essential personal attributes and relational abilities be trained?* All survey participants responded to this final question with robustly positive results: 113 (97.4%) indicated *yes* with only 3 dissenting responses (2.6%). Those who replied favorably then cited their preferred teaching strategies; again modeling and discussion—along with feedback, supervision, and role playing—were the top listed techniques.

Conversely, the three negative respondents offered opinions (a) that relational abilities and demeanor can only be built upon and (b) that these skills should be acquired prior to clinical internship. Yet, common sense would indicate that building on relational skills is always the case since it seems logical to assume that college age students already possess some level of interactive abilities. Conversely, the timing of attributes and relational training appears to be an area of contention between educators and clinical trainers as was strongly indicated not only in this final question but by the anecdotal commentary as well.

**Implications of the survey results.** Overall, the Phase Two survey results corroborated the findings from the Phase One cross comparison and illuminated the importance that music therapy educators and clinical trainers ascribed to promoting



students' acquisition of appropriate personal attributes and relational abilities.

Notwithstanding the potential disconnection between educator and student perceptions about the emphasis on training these skills and the apparent difference of educator and clinical trainer opinion as to when these abilities should be trained, overall support for focusing on these abilities remained high.

However, given the dearth of emphasis on the essential personal attributes topic in the music therapy literature along with the complexity of identifying and engendering these types of abilities cited in related literature (e.g., Munoz & Chang, 2008), the response to the final survey question was surprising. Not only did the educator and clinical trainer participants believe that these skills are highly important for a music therapist to possess, they also felt that they were currently addressing these qualities within their training and were generally successful in fostering these abilities in students and interns. This finding did appear to align Thornton's (2006) theoretical viewpoint that a therapist's personal attributes can and should be trained. Yet if this is true, why does it continue to appear that practicing music therapists differ in their ability to engender productive therapeutic relationship with clients when competency education presumes all to be equally trained?

***Open-ended comments.*** The final remarks offered by survey participants did offer more nuance to dimensions of this complex topic. The majority of the observations categorically fell along six thematic lines: essential attributes and relationship building skills should be acquired during the education process prior to internship; acquisition of these attributes is a developmental process; personal issues interfere with development of appropriate personal and relational skills; identifying essential personal attributes

represents an important research topic for the music therapy profession; most students can learn and be taught these abilities; personal attributes and relational abilities are hard to teach and difficult to assess.

Interestingly, the comments illuminated the ongoing, developmental, experiential process respondents felt was involved in acquiring essential personal and relational abilities. These ideas mirrored the role of experience emphasized by the interview participants (e.g., CT, GL, ME), concurred with the theoretical views of Milgram-Luterman (1999), and paralleled findings from the teacher effectiveness literature (e.g., Colker, 2007). Moreover, the survey commenters also highlighted what the interviewees and researchers from related fields (e.g., Aponte et al., 2009; Dunkle & Friedlander, 1996; Strand, 2000) had stressed when underscoring the importance of keen self-awareness, ego strength, confidence in one's skills, and the need to recognize and address personal issues as prerequisites to effective therapeutic intervention.

The observations also addressed the timeliness and importance of the present research topic for the music therapy profession and acknowledged that effective therapeutic intervention involves more than skills and techniques—it falls squarely on the abilities of the clinician and what that person brings to the relationship. Lastly, Phase Two contributors recognized that despite the fact that they believed that these skills are amenable to training, essential personal attributes and relational abilities are difficult to assess and far from easy to teach.

***Survey limitations.*** As is potentially true of all surveys, this instrument proved less than perfect in its content and execution. Despite the wealth of information gathered and the strong overall results, a number of inherent limitations must be acknowledged.

First, the participant sample, though fairly representative of the AMTA membership as a whole, was centered in the upper age and experience demographic of the music therapy profession. However, as evinced in membership information surveys (AMTA, 2012a), the profession is more heavily composed of younger, less experienced clinicians (61.4% < age 40). Thus, the information gathered in this research effort—though drawn from those best able to portray current education and training practices—may not accurately reflect the ideas of younger, more recently trained clinicians.

Secondly, the inherent limitations of electronic survey tools apply to this investigation as well. As noted by Thomas (2004), while electronic dissemination offers a facile, cost effective, multi-faceted, rapid means of reaching a wide geographic representation of survey participants and benefits from imbedded data analysis tools (p. 15), disadvantages include being limited to those with electronic access as well as the need for skill in developing the questions (pp. 16-17). Indeed, this survey was able to reach participants throughout the United States, proved relatively inexpensive to develop and disseminate, allowed for a variety of question formats, and gained from the internal analysis capabilities. However, distribution was limited by contact inaccuracies as demonstrated by the number of email bounce-backs and undeliverable invites (30) in the original participant list.

Moreover, development of survey content that would accurately produce the desired information proved difficult. In retrospect, choosing a five-point Likert scale for many of the questions limited the level of response nuance. For example, given only five levels of response, the categories of positive or negative response needed to be limited to two levels (e.g., highly or somewhat) leaving a center score for a neutral reaction. This

decision disallowed a middle ground response, either positive or negative, which could potentially have provided greater clarification of the opinions and ideas of survey respondents. Anecdotal commentary noted this inadequacy in several cases.

In addition, the complicated design, length, and breadth of the survey may potentially have limited participation and completion rates. As noted by pilot testers and a few participants, the survey was lengthy, asked questions that required deep reflection, and requested a level of participation atypical of many brief, uncomplicated internet surveys. This level of effort may have proven too costly for some contributors, a conjecture that was supported by the number of respondents (22) who, even after investing substantial time, did not complete the full survey.

Lastly, the third section of the survey could have benefitted from inclusion of clinical trainer questions about student response. Paralleling educator questions #29 and #30 (See Appendix D), it would have proven useful to know if student interns asked for assistance with developing relational expertise and whether they recognized the importance of possessing these qualities. Obtaining this information would have afforded comparison of educator and clinical trainer responses to determine if the potential disconnection between educator and student emphasis carried over to internship or was more of a curriculum bound issue.

Overall, however, the highly positive response, corroboration of Phase One findings, and correlation with research in related fields remain as strong testimonials to the value of the Phase Two survey results. Knowledge about the importance of what the person of the music therapist brings to the therapeutic relationship, preliminary delineation of what those essential personal attributes may encompass, designation of the

components of relationship building, and perceptions about the current status of fostering these abilities in future music therapists have all potentially been advanced by this research effort. The strong, near 50% participation level and depth of response to this survey appear to denote the importance that music therapy educators, trainers, and clinicians place on furthering the profession's understanding of this important dimension of music therapy expertise.

**Reflections on the topic: Are essential personal attributes amenable to training?** The strong positive response to the final survey question proved both surprising and exciting to this researcher. Given the long held complexities of creating relationships with others (Buber, 1970; Maslow, 1998) along with the wide variety of personal demeanors, backgrounds, expertise levels, and investiture no doubt present across the members of any profession, it would seem a daunting task to instill effective personal abilities and relational skills equally in all future music therapists. Yet, as this assuredly preliminary foray into the topic has demonstrated, even clinicians of differing backgrounds, geographic locations, personalities, and clinical emphases can and did agree on the basic elements of creating relationship as well as the essential attributes of self that engendering therapeutic liaison requires.

It probably goes without saying that individual clinicians will bring distinct personality compositions to the equation. Moreover, to assume that all music therapists should approach therapeutic alliance from the same narrow perspective would not only comprise an impossibly simplistic and limiting viewpoint, but would undoubtedly shackle much of the creativity and personal passion central to fostering productive therapeutic bonds. Instead, the music therapy profession would be better served, it seems,

by embracing the diversity that is the clinician pool. The originality, imagination, inspiration and ingenuity with which musician-therapists approach their work enable them to tap into the wealth of power that music-based relationship offers. To stifle this process by saddling clinicians with set relationship-building protocols and standards for personal interaction would serve no one—not the clinician, the profession, or the clients.

*Creating an environment and building relationships that promote student growth are the true underpinnings of a successful music therapy program*  
(Nemeth, 2006, p 141).

### **Researcher Assumptions and Guiding Statements.**

As noted at the beginning of this inquiry, the researcher held a number of assumptions and formulated several guiding statements about the topic which require re-examination in light of the investigation findings.

**Assumption #1: Engendering respectful relationship is central to effective music therapy intervention.** Both Phase One and Phase Two outcomes did appear to support this viewpoint. The interviewees articulated the importance of respectful relationship as exemplified by GL's statement: "The relationship is crucial. You damage the relationship, you're done!" Moreover, >90% of survey participants supported 14 of the 15 delineated relational attributes, with "respect" regarded as the single most important quality across all categories. The fact that seasoned clinicians as well as educators and clinical trainers all deemed this relational quality to be the most important lends further credence to this assumption.

**Assumption #2: Personal attributes and deportment are of equal importance with technical and theoretical competence.** The importance of connecting on a personal level with children and colleagues was highlighted by several of the interviewees, as evinced in AG's comment, "How are you so impressive that they don't want to run out the door," BR's remarks about recognizing what she herself brought into the relationship, and CT's emphasis on having "good working relationships, especially with nurses." The surveyed music therapy educators and clinical trainers also supported the importance of demeanor and personality as evidenced by 13 of 16 personal qualities attaining >90% agreement, with "nonjudgmental-accepting-empathetic" topping the category.

**Assumption #3: Disparities do exist in individual music therapists' abilities to engender effective relationship.** CT's remarks about "people who like to punish... people who want to have control...definitely not meant to work with children" and AG's reproach of clinicians who "pour the music therapy over a person," or who are "rigid," "non-observant" and not "engaged" exemplified views that disparities do exist among music therapists' relational abilities. Further potential support was seen in the clinical trainers' lowered perception of intern success in actual clinical settings and within anecdotal survey responses (e.g., "If they don't have the potential to develop these attributes, ideally, they should have been advised to pursue a different field"). However, many factors could be responsible for relational disparities; demeanor represents only one potential factor. Parameters of this topic require further address.

**Assumption #4: The music therapy profession does not adequately address the *person* of the music therapist within our education and training process.** Possible deficiency in attributes and demeanor training was initially supported by the dearth of

inquiry on this topic within the music therapy literature. Yet, this stance was rejected by the surveyed educators and clinical trainers who strongly indicated that they successfully address personal attributes and relational skills within their training processes. However, the noted potential discrepancy between educator and student perceptions in this area coupled with the fact that modeling was cited as the major teaching strategy raises questions. Jones and Cevalco's (2007) study which paired music therapy students with experienced therapists in the clinical setting demonstrated that simply modeling appropriate behaviors does not necessarily ensure that students will emulate these responses. In addition, education researchers (e.g., Parker & Hurry, 2007) have also noted that modelling alone, without the concomitant application of interactive strategies such as scaffolding and practice, is often insufficient in fostering skill acquisition. Relying solely on modelling—without ensuring that students are made aware of and given express opportunities for skill practice—appears to be of questionable effectiveness in light of these findings.

Moreover, current research into teaching strategies (e.g., Asberg & Sandberg, 2010; Myers, 2007; Nigro-Bruzzi & Sturmey, 2010) indicates that the best methods incorporate a combination of instructional techniques—e.g., explicit instructions, questioning-discussion, scaffolding, modeling, role play, rehearsal, and feedback. Though role playing and discussion formats were cited as prominent strategies by survey respondents, the present data did not assay whether these methods were applied discretely or in tandem. In addition, the potential passivity of discussion also raises concerns about how this strategy translates into vested action. As noted by Luce (2008), level of discussion engagement often varied across student participants. Furthermore, did cited



role playing incorporate generalization into clinical settings or remain classroom situated? It was also notable that direct coaching, an arguably more active and participatory teaching method, received far lower emphasis (< 50%) as a cited teaching strategy.

Lastly, recent investigation into collegiate pedagogy and the lack of formal teaching instruction afforded most college educators raises questions as to whether effective instructional methodology is in fact present in collegiate classrooms. As noted by Shim and Roth: “Whereas K-12 teachers must complete formal training programs to prepare for their roles and refine their teaching skills, most university professors are responsible for the evolution of their own teaching skills and abilities” (2009, p. 1). Thus, it remains incumbent upon the music therapy profession to determine the efficacy of the collegiate education and training strategies presently employed to ensure that educator perception of effective instructional techniques is indeed an actuality.

**Guiding statements:** Based on the stated researcher assumptions, the following guiding statements were developed at the onset of this investigation:

1. Effective music therapy clinicians possess personal attributes and relational abilities that align with developing a productive therapeutic relationship with child clients.
2. Educators and clinical trainers will agree that the personal attributes delineated by experienced children’s music therapists are important for all music therapists to possess.
3. Currently, development of these essential personal attributes is not adequately addressed within the education and training of music therapy students.

In reconsidering these three statements, it is clear that analytic cross comparison did demonstrate congruency among the five interviewees' ideas about the essential personal attributes they employed to effect productive therapeutic liaison with children. Likewise, the importance of these attributes gained further support from the surveyed music therapy educators and clinical trainers. Conversely, the researcher's stance that effective music therapist attributes and relational qualities are not currently addressed adequately within music therapy's education and clinical training process remains open for discussion. Potential reported disparity in educator-student perception coupled with the omission of clinical trainer questioning of student response prevents more exacting understanding in this area.

### **Implications for Further Inquiry**

This investigation represented only a preliminary foray into the topic of essential music therapist attributes and relationship-building. However, several investigative questions could be postulated from the findings. First and foremost, would wider inquiry of the profession as a whole find similarly high levels of agreement as to what comprises essential personal attributes and relational abilities of an effective music therapist? It remains necessary to test the efficacy of the present outcomes across a larger, presumably more diverse, contingent of music therapists to gain greater clarity about this topic. Given the demographics of the profession, it would also be beneficial to selectively poll both younger clinicians and minority segments of the membership to determine if possible generational or cultural differences are tacitly present.

Secondly, could the present congruence result from the situational culture found in educational or child oriented settings, a certain type of personality drawn to this type of

work, or a particular age demographic? Both the surveyed educators and clinical trainer as well as their interview counterparts heralded from a similar age bracket and worked in educational settings. It remains necessary to move beyond this demographic and setting to ascertain whether the essential personal attributes identified in this study do indeed hold as accurate across other work situations, client populations, and clinical viewpoints.

Third, as noted, all the interview participants described their initial training as behavioral in orientation. Does behavioral orientation align with clinicians who choose to work in education and child development settings or simply denote the prevalent training methodology of this particular age demographic? Moreover, does behavioral training provide the foundation for developing the eclectic orientation described by all five of the interview participants? Answers to questions such as these could provide greater understanding of the facets of effectiveness in providing music therapy services for children as well as other clientele.

In reviewing the survey responses, a number of questions pertaining to the training of future music therapists surfaced as well. Of initial concern would be ameliorating a salient shortcoming of the present inquiry—perspective on the current status of attributes instruction—by investigating students' perceptions of their training. While the current effort offered insights into the educator and clinical trainer perceptions about their effectiveness in fostering relational qualities in students, of equal interest would be student views of this process. Luce (2008), noted “a need for more research to understand music therapy students' developmental needs, to enhance teaching methods and pedagogy, and to address students' developmental needs as they prepare to enter the profession.” Polling student perceptions about their training could also address the

omission of clinical trainer questions about student response in the present survey.

It would also be useful to more thoroughly ascertain educators' and clinical trainers' processes of incorporating the plethora of required professional competencies. As noted by Bruscia: "When faced with the realities of designing curricula, developing courses, and setting up practica, educators quickly realize that priorities have to be established, and that certain competencies will have to receive less emphasis than others" (1987, p. 17). What are these processes and does the weight of competency acquisition promote an orientation towards skills and techniques that sidelines training of the person of the therapist? Delineation of the factors involved could not only offer greater clarity about how our profession prepares future clinicians, but expose where improvements can be effected as well.

Two areas that surfaced tangentially in this investigation would also benefit from address. First, the strong sentiment expressed by clinical trainers that personal attributes and relationship-building training should occur prior to internship raises another query about current educational practices. Researching where, how, and to what extent educators should be fostering students' relational skills prior to clinical placement would be useful in clarifying this process. Second, the notable response concerning lack of music therapy educator control over the student admissions is another topic in need of focus. If this deficiency proves to be widespread across programs, the ability to ensure student compatibility with the rigors of a relational profession surely suffers.

Thus, it remains necessary to extend the present research effort by attempting to verify its findings on a larger scale. The information gained during this preliminary investigation could serve to set the parameters for such wider scope inquiry, whose

results may facilitate improved training of effective music therapists. The ultimate objective of this present inquiry was to promote discussion about the need to focus on the person of the music therapist. By seeking to expose dimensions of the essential music therapist attributes necessary for effecting positive therapeutic alliance and demonstrating the importance of moving music therapy training beyond narrow emphasis on acquisition of skills, techniques, and competencies, it is hoped that this investigation will open new lines of discourse within the music therapy community.

### **Conclusion**

The results of this sequential mixed method inquiry supported the idea that one must look beyond technical skill and competence if the full dimensions of the personal and relational qualities that facilitate successful music therapy intervention are to be ascertained. Gaining understanding of the elements involved in bringing the person of the therapist into relationship with clients can only benefit the profession of music therapy. The first step is hopefully one that the present investigation has begun to address—identifying the parameters of relationship building and increasing awareness of the essential personal attributes that music therapy clinicians employ to foster productive therapeutic alliance. It is hoped that the personal, relational, cognitive, and musical attributes exposed in this research will serve as the basis for discussion about the interpersonal capacities essential to therapeutic connection.

Furthermore, employing this investigation as a stepping off point, the music therapy profession could begin to discern a more effective, coordinated approach to fostering these abilities in future clinicians and move development of the therapeutic self from what appears to be a side bar to more central focus in the training curriculum.

Consideration should be given to identifying and implementing educational processes that encompass all that the person of the music therapist can bring to bear on the work. As Hahna (2011) noted, “I am not here to teach competencies. I am here to teach music therapists” (p. 241).

Given the limited exposure that therapist attributes and relational abilities have received within music therapy discourse coupled with the strong congruency evinced among music therapy clinicians, educators and clinical trainers about the specific qualities that align with therapeutic efficacy, this researcher feels compelled to charge the music therapy profession to take a closer look at the necessity of training the *whole person* of the music therapist. It seems logical that such efforts should begin with implementation of expanded educational competencies that focus on developing clinicians’ essential attributes and relationship-building skills. The identified personal, relational, cognitive, and musical attributes along with the delineated components of relationship-building should be given greater magnification within educational competency mandates.

In addition, steps should be taken to foster discussion and express practice of relationship-building skills within music therapy training. This instructional process could potentially incorporate collaborative methodology as recently described by music therapy researchers (e.g., Baker & Krout, 2011; Luce, 2008). Employing such interactive methods would inherently combine relational practice opportunities with focus on enhancing interpersonal capacities. Moreover, instituting a coordinated continuum of personal attributes and relational instruction that begins during the education process and moves into the clinical internship setting would be beneficial not only in clarifying

implementation policies for educators and clinical trainers, but in offering consistent emphasis on the importance of acquiring relationship expertise.

Lastly, informal collegial discussion, much like the conversations that compelled this researcher to investigate the essential attributes topic, needs to move beyond anecdotal status to where the profession formally acknowledges and addresses the importance of attaining essential relational abilities. Increased grounding in the philosophical stance of Buber (1970), relational theory as described by Maslow (1998) and the relational psychologists (e.g., Miller & Stiver, 1997), and the relationship centered literature of related fields (e.g., education, counseling) could provide educators, clinicians, and students alike with a deeper understanding of relationship's importance within the therapy process. Actively employing respectful relationship language and practices while engaging with the personal attributes consistently aligned with relational efficacy could further ensure that music therapy training produces the best possible clinicians for the field. Enhanced training of the personal qualities associated with successful therapist-client relationship would not only serve to improve individual clinician effectiveness, but benefit the entire music therapy profession as well.

### *A Final Tale*

*The door to the music therapy room opens slowly. Through the gradually expanding crack, I can see two figures—one small and noticeably unsure, the other taller and encouraging. As the entry widens to full expanse, the reassuring teacher gently urges the child to move into the room. I observe the downward gaze, slumping shoulders, and fearful stance as the young person sidles hesitantly into the space. As though adhered to the wall, he seems to shrink into the woodwork surrounding the entrance.*

*It is time to go to work. I approach at snail's pace, guitar perched in my arms... the sound of simple, quiet block chords begin to fill the space between us. First a twitch of audition; then an acknowledging eyebrow....Still I approach in inches. The chord*

*changes—dominant to subdominant the sound now. I stoop my body down to eye level as I near his position...still no words, no voice to break the steady, structuring safety of musical introduction.*

*I crouch before him now and slowly push the guitar closer...no human intrusion, only a musical invitation. At first, no response...then...a minute hand movement...a slight glance upward settles on the strings near the sound hole. Tentatively, he moves a hand toward the enticing resonance. His strums soon replace mine.....and the journey begins.....*



## APPENDIX A

## IRB ACCEPTANCE LETTER

*Appendix A*

IRB Acceptance Letter



29 Everett Street

Cambridge, MA 02138

Tel 617-349-8234

Fax 617-349-8190

irb@lesley.edu

**Institutional Review Board**

May 4, 2014

To: **Jean Nemeth**

From: Robyn Cruz and Terrence Keeney, Co-chairs, Lesley IRB

RE: Application for Expedition of Review: *Essential Therapist Attributes for Effecting Positive Outcomes in Music Therapy*

**IRB Number: 10-084**

This memo is written on behalf of the Lesley University IRB to inform you that your application for approval by the IRB through expedited review has been granted. Your project poses no more than minimal risk to participants.

If at any point you decide to amend your project, e.g., modification in design or in the selection of subjects, you will need to file an amendment with the IRB and suspend further data collection until approval is renewed.

If you experience any unexpected “adverse events” during your project you must inform the IRB as soon as possible, and suspend the project until the matter is resolved.

An expedited review procedure consists of a review of research involving human subjects by an IRB co-chairperson and by one or more experienced reviewers designated by the chairperson from among members of the IRB in accordance with the requirements set forth in 45 CFR 46.110.

Source: 63 FR 60364-60367, November 9, 1998.

**Date of IRB Approval: October 5<sup>th</sup>, 2011**

APPENDIX B  
INFORMED CONSENT FORM

## *Appendix B*

### Informed Consent Form

#### **Study of Essential Therapist Attributes for Effective Music Therapy with Children**

**Principal Investigator:** Dr. Michele Forinash, Director of the PhD program

Expressive Therapies, Lesley University

**Co-investigator:** Jean M. Nemeth, MA, MT-BC

PhD Candidate, Expressive Therapies, Lesley University

You are being asked to volunteer in this study to assist in my doctoral research on creating an effective therapeutic environment when working with children. The purpose of the study is to identify those personal attributes and qualities beyond technique and skills that are possessed by music therapists who are highly effective in working with children in educational settings.

You will be participating in an open-ended interview which focuses on your process as a music therapist working with children. Initial questions will center on information about your personal background, education and training, therapeutic orientation and experience working with this population. The session will then move to an open-ended discussion focusing on your process when providing music therapy services in educational settings. A set of guiding questions will be provided to you prior to the interview so that you may begin to formulate responses to promote a more thoughtful discussion. The session will be 60-75 minutes in length and take place in a mutually agreed upon location. All content will be audio taped. Subsequent transcriptions of the session will not contain any identifying information; ancillary conversation may also be deleted. As the research progresses, the principal researcher may again contact you with follow up or clarification questions which can be administered via electronic media. A final transcript of your interview session will be provided to you.

You will be personally interacting solely with me as the principal researcher. This research project is anticipated to be finished by approximately May 2012.

I, \_\_\_\_\_, consent to participate in an open-ended interview and any necessary follow-up questioning.

I understand that:

- I am volunteering for an interview of approximately 60-75 minutes in length.

- The interview and subsequent follow up will be audio taped.
- My identity will be protected.
- Session materials, including audiotapes, transcripts, electronic communication will be kept confidential and used anonymously only, for purposes of presentation and/or publication.
- The audio recordings, transcripts, and any printed communication will be kept securely locked in the investigator's possession for possible future use. However, this information will not be used in any future study without my written consent.
- The sessions will include verbal discussion of my background, training, and career.
- I am free to end the session at any time. I am also free to withdraw from participation at any point without negative consequences. Any materials gathered will be destroyed by the researcher, upon my exit from the study.
- This study will not necessarily provide any benefits to me. However, I may experience increased self-knowledge and other personal insights that may prove useful in my work with children.

### **Confidentiality, Privacy and Anonymity:**

*You have the right to remain anonymous. If you elect to remain anonymous, we will keep your records private and confidential **to the extent allowed by law**. We will use pseudonym identifiers rather than your name on study records. Your name and other facts that might identify you will not appear when we present this study or publish its results.*

*If for some reason you do not wish to remain anonymous, you may specifically authorize the use of material that would identify you as a subject in the experiment. You can contact my advisor Dr. Michele Forinash at 617 349 8166 with any additional questions.*

*We will give you a copy of this consent form to keep.*

#### **a) Investigator's Signature:**

\_\_\_\_\_

Date

Investigator's Signature

Print Name

#### **b) Subject's Signature:**

*I am 18 years of age or older. The nature and purpose of this research have been satisfactorily explained to me and I agree to become a participant in the study as described above. I understand that I am free to discontinue participation at any time if I so choose and that the investigator will gladly answer any questions that arise during the course of the research.*

\_\_\_\_\_

Date

\_\_\_\_\_

Subject's Signature

\_\_\_\_\_

Print Name

\_\_\_\_*I respectfully decline to participate in this research study.*

*There is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Dean of Faculty or the Committee at Lesley University, 29 Everett Street, Cambridge Massachusetts, 02138, telephone: (617) 349-8517.*

*Please return this form to: Jean M. Nemeth, MA, MT-BC*

*112 O'Connell Drive*

*Berlin, CT 06037*

## APPENDIX C

## THERAPIST ATTRIBUTES GUIDING AND INTERVIEW QUESTIONS

*Appendix C*

## Therapist Attributes Guiding and Interview Questions

Jean M. Nemeth, MA, MT-BC, Interviewer

**General Guiding Questions**

1. How would you describe your orientation/style as a children's music therapist?
2. How do you go about establishing a relationship with your child clients?
3. What attitudes, personal attributes, facilitating techniques do you think are most important in developing this relationship?
4. Describe an example of a session/treatment course where you felt highly connected—where it all seemed to really work/was magical-enlivening.
5. Can you think of an instance(s) where you did not feel connected/felt frustrated or confused/where things weren't working?

Potential follow-ups: What contributed to this feeling? How did you resolve it (or not)?

**Purpose of the Study**

Purpose: The purpose of this study is to discern those qualities/attributes of experienced, successful music therapists that promote positive outcomes for children in educational settings. Your years of experience, education level, respect of professional peers, research & publications, presentation expertise, and professional awards have designated you as being experienced and effective. You have already received and signed an informed consent document that delineates both your rights and responsibilities in regards to this research effort. As you know, this interview is being recorded for data collection purposes. The information contained here will not be used for any other purpose without your express consent. In addition, you are free to withdraw from this study at any time with absolutely no repercussions.



## Complete Interview

I am most grateful to you for agreeing to participate in this interview process. Let's begin.

1. Please state your name, city/state location, degrees held/conferring school(s), professional music therapy designation and any other further training you have received--MT/non-MT
2. How many years of experience do you have working as a clinical MT?
3. How would you describe your therapeutic orientation (e.g. Behavioral/humanistic/cognitive-behavioral/psychotherapeutic/eclectic/other)?
4. What is the age range/special education designations of the students you presently serve? For how long?
5. Have you ever worked with other populations? If so, what populations—for how long?
6. What is your favorite type of music therapy work?  
Can you think of a particular instance of work you just loved doing?
7. How would you describe the style in which you work?  
What do you mean by \_\_\_\_? Can you give me an example of this?
8. Can you describe a typical format for working with children in groups?  
individually?  
Give me an example? Pick up on words use to describe & probe them.
9. Give me an example of a group session; an individual session. (Probe responses)
10. How do you go about establishing a relationship with your child clients? What does this relationship represent for you? For them?  
Talk to me about \_\_\_\_\_. (body stance/feelings/what you actually do)  
Do you mean \_\_\_\_/is it correct that you emphasize \_\_\_\_/rely on\_\_\_\_\_
11. What personal attributes do you employ when creating a relationship with children. Describe your general attitude/demeanor/style.  
Can you think of an instance where you \_\_\_\_?  
Are there any facilitating techniques you typically use?  
Any examples of this?

12. Can you think of a particular student/group that is/was special to you?

Talk to me about him-her/them.

What excites/intrigues you about this/these student(s)

13. I get the impression that you felt effective or connected with these students. What was the connection based on? What contributed to that feeling?

What do you mean by \_\_\_\_?

How did this connection make you feel?

How do you think this made your students feel?

14. What does the word attunement mean to you?

Describe a session(s) where you felt attuned to your student(s).

15. Has there ever been a time(s) when you did not feel connected with your student(s)?

How did that feel?

What did you do in this instance(s)?

What attributes/style/facilitating techniques did you use to get through it?

What was the outcome? What did you learn about yourself?

What might you do differently the 'next' time?

16. Finally, can you tell me what characteristics you think are important for a MT who works with children to possess? What ones would be detrimental?

Why do you think these are important?

Do you think any of these are more important than the others? Why?

17. Have any other thoughts about therapist attributes come up for you. Is there anything ideas you want to add? Anything you think we may have overlooked/missed?

I want to sincerely thank you for giving of your time and ideas. I found the session very enlivening and illuminating. For that you have my sincere gratitude!

APPENDIX D

PHASE TWO SURVEY

COVER LETTER, GOALS, AND QUESTIONS

*Appendix D*

## Phase Two Survey: Cover Letter, Goals, and Questions

**INTRODUCTION/COVER LETTER**

Dear Participant:

In light of the burgeoning exposure music therapy has recently received, it is imperative that our profession be positioned to provide highly qualified practitioners to meet potentially expanding demand. In addition to being armed with cutting edge knowledge and skills, these practitioners must also possess personal qualities appropriate for engendering productive therapeutic liaison with potential clients. It may well be that a music therapist's personal attributes will prove as crucial as specific training or theoretic orientation in opening doors and creating access to music therapy services.

The following survey is being undertaken as part of a doctoral research study entitled, "Essential Music Therapist Attributes for Fostering Productive Outcomes with Children." This study seeks to identify those personal qualities of a music therapist that are essential in establishing a productive therapeutic relationship with child clients. Drawing on responses gleaned from in-depth interviews with highly experienced children's music therapists, this survey intends to further delineate these qualities and determine how development of these attributes is addressed within the training of music therapy students.

You are being invited to participate in this survey in your capacity as a music therapy educator or clinical trainer. As such, you are uniquely qualified to demarcate those aspects of the overall music therapy education process which focus on the development of appropriate personal demeanor in future music therapists. Your input is highly pertinent and perhaps critical to the future success of music therapy practitioners in the marketplace. The survey will take approximately 15-20 minutes to complete and submission will serve as participatory consent. Demographic information is being gathered solely for research purposes; your anonymity will be safeguarded. Additionally, you are free to withdraw from participating at any time. Please click on the provided link below.

Given the competing demands on music therapy professionals' time, I would sincerely like to thank you for your willingness to participate in this survey. Your opinions and information are vital to the success of this project and may well have impact on the future growth of our profession. Please forward any questions or comments you may have pertaining to this survey to [jnemeth@lesley.edu](mailto:jnemeth@lesley.edu). Thank you in advance for your assistance with this project.

Sincerely,

Jean M. Nemeth, MA, MT-BC  
Expressive Therapies Doctoral Candidate  
Lesley University  
Cambridge, MA

## **SURVEY GOALS & OBJECTIVES:**

### **GOALS:**

To increase understanding and awareness of the personal qualities of a music therapist that are essential in fostering a productive working relationship with children.

To identify and illuminate whether and how the training of these personal qualities is incorporated into the education of new music therapists.

### **OBJECTIVES:**

1. To collect evidence as to whether music therapy educators and clinical trainers agree/disagree with the accuracy and importance of previously identified attributes of effective children's music therapists.
2. To collect information regarding where and how these attributes are identified and taught within college music therapy curricula.
3. To collect information regarding where and how these attributes are identified and fostered within music therapy clinical training programs.
4. To gather opinions about the necessity and possibility of instilling these attributes into future music therapists.

## **ESSENTIAL MUSIC THERAPIST ATTRIBUTES SURVEY QUESTIONS**

### **DEMOGRAPHICS:**

1. Please indicate your professional music therapy designation:  
 a. MT-BC      b. RMT      c. CMT
  
2. Years as a Music Therapy Professional (Choose one):  
 Less than 5:    6-10      11-15      16-20      21-25      26 or longer  
 Clinician:  
 Educator:  
 Clinical Trainer:
  
3. Highest Level of Education Completed:  
 a. Bachelors      b. Masters      c. Sixth Year      d. Doctorate
  
4. Your Age:    25-30:    31-40:    41-50:    Over 50:
  
5. Gender:    Male\_\_\_\_    Female\_\_\_\_
  
6. What would you describe as your primary ethnicity?  
 a. Caucasian/White  
 b. Black/African American  
 c. Latin/Hispanic  
 d. Asian/Polynesian  
 e. Native American  
 f. Middle Eastern/Arabic  
 g. Indian  
 h. Other \_\_\_\_\_

### **SECTION 1: ESSENTIAL MUSIC THERAPIST ATTRIBUTES**

Using the following scale, please rate the **importance** of the following **personal qualities** of music therapist in promoting an effective therapeutic relationship with children:

A = Very important    B = Somewhat important    C = Neither important or unimportant  
 D = Of low importance    E = Not important

### **7. PERSONAL QUALITIES (Circle One Answer for each entry):**

1. Being Flexible    A B C D E

2. Being Open Minded/Spontaneous A B C D E
3. Being Nonjudgmental/Accepting/Empathetic A B C D E
4. Being Honest/Authentic/Genuine/Sincere A B C D E
5. Displaying Commanding Presence A B C D E
6. Being Enthusiastic/Engaging/Animated A B C D E
7. Possessing Strong Self Awareness/Personal Insight A B C D E
8. Being Self Confident/Possessing Positive Self Esteem A B C D E
9. Having Good Personal Boundaries A B C D E
10. Being Patient A B C D E
11. Being Structured/Predictable A B C D E
12. Being Happy/Playful/Fun Loving/Humorous A B C D E
13. Being Nonthreatening A B C D E
14. Passionate about children/music therapy A B C D E'
15. Stable/Reliable/Self Reliant A B C D E

If applicable, please add any other **personal qualities** you find important (You may leave these blank):

16. Other: \_\_\_\_\_ 17. Other: \_\_\_\_\_

8. Of the above delineated **personal qualities**, please identify the **five** qualities you feel most important for a music therapist to possess (in rank order):

1st. \_\_\_\_ 2nd. \_\_\_\_ 3rd. \_\_\_\_ 4th. \_\_\_\_ 5th. \_\_\_\_

**9. RELATIONAL QUALITIES** (Circle One Answer for each entry):

1. Respect for children A B C D E
2. Respect for the therapy process A B C D E
3. Respect for family/culture A B C D E
4. Being Child Centered A B C D E
5. Being Connected/Attuned/Fully Present A B C D E
6. Being Emotionally Engaged A B C D E
7. Caring/Accepting/Valuing child A B C D E
8. Empowering child A B C D E
9. Creating a safe environment A B C D E
10. Seeing Role as a Guide vs. a Leader A B C D E
11. Engendering Trust A B C D E
12. Providing Appropriate Self Disclosure A B C D E
13. Fostering independence A B C D E
14. Focusing on positives/Believing in Client's Ability to Succeed A B C D E

If applicable, please add any other **Relational Qualities** you deem important (You may leave these blank):

16. Other: \_\_\_\_\_

17. Other: \_\_\_\_\_

10. Of the above delineated **Relational Qualities**, please identify the **five** qualities you feel most important for a music therapist to possess (in rank order):

1st. \_\_\_\_ 2nd. \_\_\_\_ 3rd. \_\_\_\_ 4th. \_\_\_\_ 5th. \_\_\_\_

### 11. COGNITIVE ABILITIES (Circle One Answer for Each Entry):

1. Possess Strong Observational Abilities A B C D E
2. Possess Strong Evaluation/Assessment/Interpretation Skills A B C D E
3. Possess Flexibility in Thinking A B C D E
4. Be Creative A B C D E
5. Possess Theoretical Knowledge A B C D E
6. Remain A Learner A B C D E
7. Accept Supervision/See Alternate Viewpoints A B C D E
8. Possess Good Communication Skills A B C D E
9. Ability to Structure Effective Environment A B C D E
10. Possess Good Listening Abilities A B C D E
11. Ability to task analyze A B C D E
12. Ability to individualize A B C D E

If applicable, please add any other **Cognitive Abilities** you deem important (You may leave these blank):

16. Other: \_\_\_\_\_

17. Other: \_\_\_\_\_

12. Of the above delineated **Cognitive Abilities**, please identify the **Five** abilities you feel most important for a music therapist to possess (in rank order):

1st. \_\_\_\_ 2nd. \_\_\_\_ 3rd. \_\_\_\_ 4th. \_\_\_\_ 5th. \_\_\_\_

### 13. MUSICAL ATTRIBUTES (Circle One Answer for Each Entry):

1. Possess Strong Musicianship A B C D E
2. Utilize high quality music A B C D E
3. Ability to individualize Music A B C D E
4. Personal deep connection/passion/love for music A B C D E
5. Strong improvisational skills A B C D E
6. View Music as a Powerful Tool A B C D E
7. Understand the Social Nature of Music A B C D E
8. Understand Music as Nonverbal Communication A B C D E



9. Emphasize Music as Process not Product A B C D E  
 10. See Music as Co-Therapist/Take a Musician + Therapist Stance A B C D E  
 11. Emphasize Live vs. Recorded Music A B C D E

If applicable, please add any other **Musical Attributes** you deem important (You may leave these blank):

12. Other: \_\_\_\_\_ 13. Other: \_\_\_\_\_

14. Of the above delineated **Musical Attributes**, please identify the **Five** attributes you feel most important for a music therapist to possess (in rank order):

1. \_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_ 4. \_\_\_\_ 5. \_\_\_\_

## **SECTION II: TRAINING OF MUSIC THERAPIST PERSONAL ATTRIBUTES**

Please rate your agreement with the following statements according to the following scale (Circle ONE Answer per Entry):

- A. Highly agree B. Somewhat agree C. Not agree or disagree  
 D. Somewhat disagree E. Strongly disagree

15. It is important and necessary to address the personal attributes and demeanor in the training of music therapy students. A B C D E

16. In selecting students for my program, I evaluate personal attributes and relational abilities as part of the admission process. A B C D E

17. In my setting, students are expected to possess good relationship building skills before entering my program. A B C D E

18. In my setting, discussion of personal attributes and demeanor is incorporated into my education/ clinical training process. A B C D E

19. In my setting, expectations are clearly delineated about how music therapy students are to employ personal attributes when interacting with clients. A B C D E

20. In my setting, I regularly model appropriate relationship building skills for my students/interns. A B C D E

21. My course curriculum/internship protocols incorporate the teaching of relationship building.

A B C D E

22. My students/interns are provided with opportunities to practice relationship building skills during class, supervision, peer group, or other formal settings. A B C D E

23. In my setting, relationship building skills are expressly taught before music therapy students/interns are allowed to engage in direct therapy with clients. A B C D E

24. I consider personal attributes and relationship building skills to be important for the future success of music therapy students. A B C D E

### **SECTION III: MUSIC THERAPY EDUCATION & CLINICAL TRAINING PROCESS**

25. What is your professional Music Therapy capacity?

- a. Music Therapy Educator
- b. Music Therapy Clinical Training Director
- c. Clinical Training Supervising Music Therapist
- d. Other (Please specify: \_\_\_\_\_)

### **THE MUSIC THERAPY EDUCATION PROCESS**

26. How important do you feel it is to incorporate the development of interpersonal and relationship building expertise in the training of your students?

Highly important \_\_\_\_ Somewhat important \_\_\_\_ Neither important nor unimportant \_\_\_\_  
 Of low importance \_\_\_\_ Not important at all \_\_\_\_

27. Does your program's curriculum formally address personal attributes and relationship building within required music therapy coursework? (Circle one): YES NO

If yes, please list the three courses where these components are most fully addressed:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If yes, specifically how do you address the development of student's personal attributes and Relationship-building within your classrooms? (Check all that apply):

Modeling \_\_\_\_ Role Playing \_\_\_\_ Peer Discussions \_\_\_\_ Group  
 Discussion \_\_\_\_ Individual Discussion with Student \_\_\_\_

Within Individual Supervision \_\_\_\_\_ Direct Coaching \_\_\_\_\_  
 Other: \_\_\_\_\_ Other: \_\_\_\_\_

If no, are informal opportunities provided to students that address these components?  
 YES NO

Please list the three most prominent areas:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

28. How often do students request assistance with development of relationship building expertise?

Frequently \_\_\_\_ Occasionally \_\_\_\_ Almost Never \_\_\_\_

29. Do students appear to recognize the importance of possessing strong relationship building skills? YES NO

30. How often do you emphasize the importance of a music therapist's personal demeanor in building appropriate therapeutic relationship with clients?

Constantly \_\_\_\_ Frequently \_\_\_\_ Occasionally \_\_\_\_ Almost Never \_\_\_\_

31. How successful do you feel you are in instilling strong relationship building skills in your interns?

Highly successful \_\_\_\_ Mostly successful \_\_\_\_ Somewhat successful \_\_\_\_  
 Somewhat unsuccessful \_\_\_\_ Generally unsuccessful \_\_\_\_

## THE CLINICAL TRAINING PROCESS

32. How important do you feel it is to incorporate the development of interpersonal and relationship building expertise in the training of your interns?

Highly important \_\_\_\_ Somewhat important \_\_\_\_  
 Neither important nor unimportant \_\_\_\_  
 Of low importance \_\_\_\_ Not important at all \_\_\_\_

33. Do you expect interns to enter your setting already possessing strong relational abilities? YES NO

34. Do you attempt to assess these skills in internship applicants during the internship interview process? YES NO

35. Does your internship program formally address personal attributes and relationship building within the training of your interns? (Circle one): YES NO

If Yes, specifically how do you address the development of an intern's personal attributes and relationship building within your setting? (Check all that apply):

Modeling \_\_\_\_\_ Role Playing \_\_\_\_\_ Peer Discussions \_\_\_\_\_  
 Group Discussion \_\_\_\_\_ Individual Discussion with Intern \_\_\_\_\_  
 During Supervision \_\_\_\_\_ Direct Coaching \_\_\_\_\_  
 Other: \_\_\_\_\_ Other: \_\_\_\_\_

36. How successful do you feel you are in instilling strong relationship building skills in your interns?

Highly successful \_\_\_\_\_ Mostly successful \_\_\_\_\_ Somewhat successful \_\_\_\_\_  
 Somewhat unsuccessful \_\_\_\_\_ Generally unsuccessful \_\_\_\_\_

## FINAL THOUGHTS

37. Do you feel that it is possible to foster appropriate personal attributes and relational abilities in your music therapy students? YES NO

If Yes, list your three most successful strategies for fostering these skills:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If No, list the three most prominent reasons you feel it is NOT possible to teach these skills:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

38. Please describe any further thoughts or ideas you may have about fostering essential personal attributes and relational skills in your music therapy students/interns. Your ideas will be most useful to the further delineation of this important topic and are greatly appreciated.

I would like to sincerely thank you for participating in this survey. Your input and ideas are not only of great importance to the success of this study, but more importantly may prove most helpful in the improving future training of highly competent music therapists. This researcher is much indebted to your efforts on her behalf.

## APPENDIX E

## PHASE TWO SURVEY INVITATION LETTER AND LINK

## Appendix E

### Phase Two Survey Invitation Letter and Link



#### ATTENTION ALL MUSIC THERAPY EDUCATORS AND CLINICAL TRAINERS

You are cordially invited to participate in a survey that seeks to identify the essential personal attributes that a music therapist employs when establishing productive therapeutic relationships and determine how development of these qualities is addressed within the training of music therapy students. This survey is being conducted as part of a doctoral research study entitled: *Essential Music Therapist Attributes for Fostering Productive Outcomes with Children*. As a music therapy educator or clinical trainer, you are uniquely qualified to demarcate those aspects of the music therapy education process which focus on the development of appropriate personal demeanor in future music therapists. Though the study outcomes will ultimately focus on work with children, this survey is designed to gather general information about current education and training practices and is not intended to be child specific.

The survey will take approximately 15-20 minutes to complete. Demographic information is being gathered solely for research purposes; your anonymity will be closely safeguarded in accordance with Lesley University IRB standards. For further information about the IRB approval process, please contact IRB Co-chairperson Dr. Robyn Cruz ([rcruz@lesley.edu](mailto:rcruz@lesley.edu)). Completion of the survey will serve as participatory consent; however, you are free to withdraw from this study by not submitting the survey.

Given the competing demands on music therapy professionals' time, I would sincerely like to thank you for your willingness to participate in this survey. Your opinions and information are vital to the success of this project and could potentially impact the training of future music therapists and growth of our profession. Requests for further information pertaining to this survey should be directed to [jnemeth@lesley.edu](mailto:jnemeth@lesley.edu). Questions related to the Lesley University Doctoral program and research protocols should be directed to research advisor, Dr. Michele Forinash ([forinasm@lesley.edu](mailto:forinasm@lesley.edu)). Thank you in advance for your assistance with this research endeavor. Please click the link below to begin:

<http://s-297095-i.sgizmo.com/s3/i-100202751-376022/?sguid=100202751>

Sincerely,

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## APPENDIX F

## FULL RESPONSE CONTENT OF PHASE TWO SURVEY

*Appendix F*

**Full Response Content of Phase Two Survey:**

**Section One: Essential Music Therapist Attributes**

**7. AREA # 1: PERSONAL QUALITIES:**

	<b>Very important</b>	<b>Somewhat important</b>	<b>Neither important or unimportant</b>	<b>Of little importance</b>	<b>Not important</b>	<b>Total</b>
<b>1. Be Flexible</b>	<b>89.0%</b> 113	<b>11.0%</b> 14	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 127
<b>2. Be Open Minded/ Spontaneous</b>	<b>80.8%</b> 101	<b>19.2%</b> 24	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 125
<b>3. Be Nonjudgmental/ Accepting/Empathetic</b>	<b>94.5%</b> 120	<b>5.5%</b> 7	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 127
<b>4. Be Honest/ Authentic/Genuine/ Sincere</b>	<b>95.3%</b> 121	<b>4.7%</b> 6	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 127
<b>5. Display Commanding Presence</b>	<b>7.1%</b> 9	<b>57.5%</b> 73	<b>29.1%</b> 37	<b>4.7%</b> 6	<b>2.4%</b> 3	<b>100%</b> 127
<b>6. Be Enthusiastic/ Engaging/Animated</b>	<b>39.4%</b> 50	<b>51.2%</b> 65	<b>9.4%</b> 12	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>100%</b> 127
<b>7. Possess Strong Self Awareness/Personal Insight</b>	<b>79.5%</b> 101	<b>19.7%</b> 25	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 127
<b>8. Be Self-Confident/ Possess Positive Self Esteem</b>	<b>66.1%</b> 82	<b>32.3%</b> 40	<b>1.6%</b> 2	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 124
<b>9. Possess Good Personal Boundaries</b>	<b>86.5%</b> 109	<b>13.5%</b> 17	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 126
<b>10. Be Patient</b>	<b>83.2%</b> 104	<b>12.8%</b> 16	<b>4.0%</b> 5	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 125
<b>11. Be Structured/ Predictable</b>	<b>20.0%</b> 25	<b>60.0%</b> 75	<b>13.6%</b> 17	<b>6.4%</b> 8	<b>0.0%</b> 0	<b>100%</b> 125
<b>12. Be Happy/Playful/ Fun Loving/ Humorous</b>	<b>19.0%</b> 24	<b>59.5%</b> 75	<b>16.7%</b> 21	<b>5.6%</b> 7	<b>0.0%</b> 0	<b>100%</b> 126
<b>13. Be Nonthreatening</b>	<b>71.7%</b> 91	<b>24.4%</b> 31	<b>4.7%</b> 6	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 127
<b>14. Be Passionate about Clients</b>	<b>65.1%</b> 82	<b>31.0%</b> 39	<b>4.0%</b> 5	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 126
<b>15. Be Passionate about Music Therapy</b>	<b>68.8%</b> 86	<b>28.0%</b> 35	<b>2.4%</b> 3	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>100%</b> 125
<b>16. Be Stable/Reliable/ Self Reliant</b>	<b>88.0%</b> 110	<b>11.2%</b> 14	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 125
<b>#4 &amp; #11 are situation specific</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1
<b>17. Have good communication skills</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1



Ability to be completely present in the moment.	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Able to be connected with client in the present not distracted by things outside present	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be Creative	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be Ethical	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be Present	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be able to collaborate	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be an attentive listener/observer	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be caring, compassionate	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be prudent, able to make good decisions	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be strongly connected to your own feelings	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Curious	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Display good self-care behavior	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Emotionally stable enough to know when to be vulnerable, and to what degree.	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Good communicator	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Good documentation and communication skills	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Groundedness/Strength of Character	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Intelligent	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Possess a desire to help/heal	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Sensitivity	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Creative	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Eager to learn	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Have vision	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Have good instincts	0.0% 0	100.0% 1	0.0% 0	0.0% 0	0.0% 0	100% 1
Sense of humor	0.0% 0	100.0% 1	0.0% 0	0.0% 0	0.0% 0	100% 1

## 9. Area #2: RELATIONAL ABILITIES:

	Very important	Somewhat important	Neither important or unimportant	Of little importance	Not important	Total
1. Have Respect for Client	98.4% 120	0.8% 1	0.8% 1	0.0% 0	0.0% 0	100% 122
2. Have Respect for the Therapy Process	82.8% 101	16.4% 20	0.8% 1	0.0% 0	0.0% 0	100% 122
3. Have Respect for Client's Family & Family Values	80.3% 98	18.0% 22	1.6% 2	0.0% 0	0.0% 0	100% 122
4. Have Respect for Client's Culture	80.3% 98	19.7% 24	0.0% 0	0.0% 0	0.0% 0	100% 122
5. Be Client Centered	82.0% 100	18.0% 22	0.8% 1	0.0% 0	0.0% 0	100% 122
6. Be Connected/Attuned/Fully Present	91.8% 112	7.4% 9	0.8% 1	0.0% 0	0.0% 0	100% 122
7. Be Emotionally Engaged	49.2% 60	45.1% 55	5.7% 7	0.8% 1	0.0% 0	100% 122
8. Be Caring/Accepting; Value Client	86.1% 105	13.9% 17	0.0% 0	0.0% 0	0.0% 0	100% 122
9. Empower Client	75.4% 92	23.8% 29	0.8% 1	0.0% 0	0.0% 0	100% 122
10. Create a Safe Environment	93.5% 115	5.7% 7	0.8% 1	0.0% 0	0.0% 0	100% 123
11. See MT's Role as a Guide versus as a Leader	41.3% 50	52.1% 63	8.3% 10	0.0% 0	0.0% 0	100% 121
12. Engender Trust	85.0% 102	15.0% 18	0.0% 0	0.0% 0	0.0% 0	100% 120
13. Provide Appropriate Self Disclosure	41.0% 50	44.3% 54	10.7% 13	3.3% 4	0.8% 1	100% 122
14. Foster Client Independence	65.6% 80	32.8% 40	2.5% 3	0.0% 0	0.0% 0	100% 122
15. Focus on Positives/Believe in Client's Ability to Succeed	70.5% 86	28.7% 35	1.6% 2	0.0% 0	0.0% 0	100% 122
Be a good listener	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Respect client's already established relationship with music	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Mindfulness	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Be courageous	0.0% 0	100.0% 1	0.0% 0	0.0% 0	0.0% 0	100% 1

### 11. Area #3: COGNITIVE ABILITIES:

	<b>Very important</b>	<b>Somewhat important</b>	<b>Neither important or unimportant</b>	<b>Of little importance</b>	<b>Not important</b>	<b>Total</b>
<b>1. Possess Strong Observational Abilities</b>	<b>92.6%</b> 112	<b>7.4%</b> 9	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>2. Possess Strong Evaluation/Assessme nt/Interpretation Skills</b>	<b>82.6%</b> 100	<b>17.4%</b> 21	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>3. Be Flexible in Thinking</b>	<b>78.5%</b> 95	<b>20.7%</b> 25	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>4. Be Creative</b>	<b>74.4%</b> 90	<b>25.6%</b> 31	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>5. Possess Theoretical Knowledge</b>	<b>55.4%</b> 67	<b>43.8%</b> 53	<b>1.7%</b> 2	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>6. Remain A Learner</b>	<b>85.1%</b> 103	<b>15.7%</b> 19	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>7. Accept Supervision/See Alternate Viewpoints</b>	<b>82.6%</b> 100	<b>17.4%</b> 21	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>8. Possess Good Communication Skills</b>	<b>91.7%</b> 111	<b>8.3%</b> 10	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>9. Be Able to Structure Effective Environment</b>	<b>80.2%</b> 97	<b>19.0%</b> 23	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>10. Possess Good Listening Abilities</b>	<b>95.0%</b> 115	<b>5.0%</b> 6	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>11. Be Able to Task Analyze</b>	<b>58.7%</b> 71	<b>38.0%</b> 46	<b>3.3%</b> 4	<b>0.8%</b> 1	<b>0.0%</b> 0	<b>100%</b> 121
<b>12. Be Able to Individualize</b>	<b>82.6%</b> 100	<b>17.4%</b> 21	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 121
<b>13 Ability to quickly think about solutions in session and act upon them</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1
<b>Be able to assess own + &amp; -</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1
<b>Intelligent</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1
<b>Quick thinking</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1
<b>Understand organizational dynamics</b>	<b>100.0%</b> 1	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>0.0%</b> 0	<b>100%</b> 1

### 13. Area #4: MUSICAL ATTRIBUTES:

	Very important	Somewhat important	Neither important or unimportant	Of little importance	Not important	Total
1. Possess Strong Musicianship	86.4% 102	12.7% 15	0.8% 1	0.0% 0	0.0% 0	100% 118
2. Utilize High Quality Music	60.3% 70	33.6% 39	5.2% 6	0.9% 1	0.0% 0	100% 116
3. Be Able to Individualize Music	88.0% 103	12.0% 14	0.0% 0	0.0% 0	0.0% 0	100% 117
4. Possess a Deep Personal Connection/ Passion/Love for Music	56.8% 67	38.1% 45	5.1% 6	0.0% 0	0.0% 0	100% 118
5. Possess Strong Improvisational Skills	32.5% 38	59.0% 69	8.5% 10	0.0% 0	0.0% 0	100% 117
6. View Music as a Powerful Tool	82.2% 97	17.8% 21	0.0% 0	0.0% 0	0.0% 0	100% 118
7. Understand the Social Nature of Music	53.8% 63	39.3% 46	6.8% 8	0.0% 0	0.0% 0	100% 117
8. Understand Music as a Nonverbal Mode of Communication	78.6% 92	18.8% 22	2.6% 3	0.0% 0	0.0% 0	100% 117
9. Emphasize Music Making as a Process not as a Product	81.9% 95	15.5% 18	2.6% 3	0.0% 0	0.0% 0	100% 116
10. See Music as an MT's Co-Therapist/Take a Musician + Therapist Stance	50.9% 59	31.9% 37	15.5% 18	0.9% 1	0.9% 1	100% 116
11. Emphasize Live Music over Recorded Music	41.4% 48	43.1% 50	16.4% 19	0.9% 1	0.0% 0	100% 116
12 Be a lifelong music learner	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
12. Strong vocal skills	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Curious about role of music in individual's life	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Knowledge of many genres of music	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Live vs. recorded depends on the intervention, the patient's needs, etc. recorded music is a tool not to be ruled out.	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
Versatile musician	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1

Be musically interactive	100.0% 1	0.0% 0	0.0% 0	0.0% 0	0.0% 0	100% 1
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